



## DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

### Doctorate in Clinical Psychology: Main Research Portfolio

**1) A critical literature review of the extent and quality of research into post bereavement support provided by UK and Ireland hospices for family and carers; 2) Service Improvement Project paper: An evaluation of 'suicide risk training' for General Practitioners; 3) Reassurance seeking in OCD and depression**

Smith, Emma

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# Research Portfolio Submitted in Part Fulfilment of the Requirements for the Degree of Doctorate in Clinical Psychology

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Emma Smith

Doctorate in Clinical Psychology

University of Bath  
Department of Psychology

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## **Word Counts**

Literature Review paper	6,416
Service Improvement Project paper	4,650
Main Research Project Paper	5,694
Executive Summary of Main Research	509
Connecting Narrative	2,519

## **Abstract**

### **Main Research Project**

*Background and Objectives:* It has been suggested that reassurance seeking may play an important role in the development and maintenance of common mental health problems such as OCD and depression. We first considered the extent of reassurance seeking in depression and OCD relative to a healthy comparison group and secondly tested the hypothesis that reassurance seeking is primarily motivated by threat in those suffering from OCD and by interpersonal concerns in those suffering from depression.

*Methods:* The frequency and intensity of reassurance seeking and the motivation for seeking reassurance was measured using the reassurance seeking questionnaire in 28 people with OCD, 18 people with depression and 29 healthy controls.

*Results:* The OCD group sought reassurance more and at a higher intensity than both the depression group and healthy controls. For the OCD group, reassurance seeking was found to be linked to threat concern motivation. The depression group were not motivated by threat or interpersonal concerns.

*Conclusions:* For people suffering from OCD, reassurance is motivated by threat concern. For the depression group the motivation to seek reassurance is less clear but interpersonal concern may not be a distinct motivational factor.

*Key words:* Reassurance seeking, Obsessive-Compulsive Disorder, depression, reassurance seeking questionnaire, threat motivation, interpersonal motivation.

### **Service Improvement Project**

*Objective:* In the UK suicide rates have been increasing since 2008. The aim of this study was to evaluate the suicide risk training provided by LIFT psychology to GPs. *Method:* All 145 GPs in Swindon were asked to complete a brief questionnaire about their experience of the suicide risk training provided by LIFT psychology. The questionnaire was completed by seven GPs who had done the training and by 23 GPs who had not done the training.

*Results:* The GPs who took part in the suicide risk training reported it as helpful. However 91% of GPs who did not complete the training reported that they were not given the option to take part. *Conclusion:* GPs reported that the suicide risk training was useful but it is currently only offered on an ad-hoc basis which is not in line with the evidence base.

*Recommendations:* For LIFT psychology to create a system for monitoring which GPs take part in the training, to evaluate the training on a frequent basis and to ensure that training is delivered in line with the evidence base.

## **Literature Review**

The nature and quality of bereavement support provided in hospices is largely under-examined. Currently there is no ‘best practice’ for hospices to implement when delivering bereavement support. This review evaluates the extent and quality of post bereavement support provided by hospices in the UK and Ireland. A systematic search of four electronic databases (PubMed, PsychNET, SCOPUS and Cochrane), yielded 634 articles, 12 of which met the inclusion criteria. This review synthesises and critically evaluates the literature, drawing on a grading criterion for review of carer intervention studies. The overall findings highlight significant limitations in terms of the amount, quality and rigour of the studies conducted. This makes it difficult to give evidence-based recommendations on the effectiveness of providing specific types of bereavement support. The types of bereavement support provided in the hospices varied widely from telephone support to one-to-one listening. To adhere to NICE guidelines hospices should complete an individual bereavement risk assessment to determine a person’s level of bereavement support needs. This review emphasises the importance drawing on theoretical models of bereavement for informing any bereavement support. Future research in this area would benefit from developing more rigorous research protocols.

**Key words:** Bereavement; Grief; Hospice; Bereavement support; Family; Carers.

## **Table of Contents**

6	<b>Literature Review: A critical literature review of the extent and quality of research into post bereavement support provided by UK and Ireland hospices for family and carers</b>
7	Abstract
8	Introduction
11	Method
13	Results
27	Discussion
32	References
36	<b>Service Improvement Project paper: An evaluation of ‘suicide risk training’ for General Practitioners</b>
37	Abstract
38	Summary of the literature
40	Method
42	Results
45	Discussion
50	Service response
52	References
55	<b>Main Research Paper: Reassurance seeking in OCD and depression</b>
56	Abstract
57	Introduction
60	Method
66	Results
70	Discussion
75	References
78	Executive summary of Main Research Project
80	Connecting narrative
87	<b>Appendix A:</b> <i>Bereavement Care</i> instructions for authors
90	<b>Appendix B:</b> <i>BMJ Quality &amp; Care</i> instructions for authors
92	<b>Appendix C:</b> Suicide risk training questionnaire
95	<b>Appendix D:</b> Service improvement project participant information sheet
97	<b>Appendix E:</b> Service improvement project consent form
98	<b>Appendix F:</b> <i>Behaviour Therapy and Experimental Psychiatry</i> instructions for authors

101	<b>Appendix G:</b> Reassurance seeking questionnaire
104	<b>Appendix H:</b> IRAS ethical approval letter
109	<b>Appendix I:</b> Everyone Included letter
111	<b>Appendix J:</b> Main research project participant information sheet
113	<b>Appendix K:</b> Main research project consent form

**A critical literature review of the extent and quality of research in post bereavement support provided by UK and Ireland hospices for family and carers**

Emma Smith

Doctoral Programme in Clinical Psychology, Department of Psychology, University of Bath, Claverton Down, Bath, BA2 7AY, Tel: 01225 385506, Email: [es600@bath.ac.uk](mailto:es600@bath.ac.uk)

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Proposed Journal: *Bereavement Care* (word count: 5,000)

(see appendix A)

This journal was chosen due to the relevance of its content and because it is targeted at those who work with bereaved people.

## **Abstract**



The nature and quality of bereavement support provided in hospices is largely under-examined. Currently there is no ‘best practice’ for hospices to implement when delivering bereavement support. This review evaluates the extent and quality of research in post bereavement support provided by hospices in the UK and Ireland. A systematic search of four electronic databases (PubMed, PsychNET, SCOPUS and Cochrane), yielded 634 articles, 12 of which met the inclusion criteria. This review synthesises and critically evaluates the literature, drawing on a grading criterion for review of carer intervention studies. The overall findings highlight significant limitations in terms of the amount, quality and rigour of the studies conducted. This makes it difficult to give evidence-based recommendations on the effectiveness of providing specific types of bereavement support. The types of bereavement support provided in the hospices varied widely from telephone support to one-to-one listening. To adhere to NICE guidelines hospices should complete an individual bereavement risk assessment to determine a person’s level of bereavement support needs. This review emphasises the importance drawing on theoretical models of bereavement for informing any bereavement support. Future research in this area would benefit from developing more rigorous research protocols.

**Key words:** Bereavement; Grief; Hospice; Bereavement support; Family; Carers.

## **Introduction**

## **Bereavement**

In the United Kingdom (UK), trends show that people are living longer and dying at an older age. With an ageing population, it has been predicted that by 2035 over half of deaths will be of people aged 85 years and older (Office for National Statistics, 2012). Older people are most likely to choose to die in a hospice setting (Calanzani, Higginson & Gomes, 2013). The loss of a loved one can be associated with high distress and mental and physical health problems (Parkes, 1996; Stroebe, Stroebe & Hansson, 1993). The potential impact of bereavement highlights the importance of providing support during this time. This is particularly important in hospices, where death is an inevitable part of the care.

## **Hospices**

Hospices provide support to people suffering from a terminal illness and to their family members and/or carers, at the final stages of their life. Hospices also provide continuing care to relatives after a death, as most hospices have recognised that carers and family members have continuing needs after the death of a loved one. However, while the provision of bereavement support is now an integral part of the care delivered by most hospices (Payne, Smith & Dean, 1999), the nature and quality of bereavement support provided by them is largely under-examined in the literature (Reid, Field, Payne & Relf, 2006).

## **National Policy**

National Institute for Health and Care Excellence (NICE) guidelines have emphasised the importance of delivering appropriate bereavement support through adequate assessment of bereavement needs (NICE, 2004). This is crucial because providing bereavement support when it is not necessary can be unhelpful (Schut & Stroebe, 2005). A systematic literature review has evaluated the usefulness of different assessment measures in determining a person's level of bereavement needs (Agnew, Manktelow, Taylor & Jones, 2010). This review highlighted a range of appropriate risk assessment measures such as the Texas Revised Inventory of Grief (TRIG), which is useful for making a distinction between normal and complicated grief, and the Adult Attitude to Grief Scale (AAG). The AAG is based on Machin's Range of Response to Loss model (Machin, 2007; Machin & Spall, 2004). The paper concluded that the AAG has good face validity and is an appropriate measure to use within a UK hospice bereavement service (Agnew et al., 2010).

In the UK and Ireland, national guidance recommends that bereavement care is delivered on a three-component model (National Advisory Committee in Palliative Care, NACPC, 2011; NICE, 2004). The NACPC and NICE guidelines recommend that cancer networks, which include hospices, should develop and implement this three-component model of bereavement support. Level one refers to providing information about the experience of bereavement and ways to access support. Level two involves providing a more formal opportunity for people to process their bereavement experience, with either professionals or volunteers, in an individual or group setting. Level three is required for more complicated grief reactions and involves specialist interventions that potentially require a referral to another service. Currently, there is no guidance on how these services should be delivered (NICE, 2004). Research has found that bereavement support in UK hospices tends to be delivered at levels one and two (Kissane, 2004). Furthermore, key commentators in this field have highlighted that it is ethically important to evaluate bereavement services properly so that any support given is evidence-based (Parkes, 1995).

### **Theoretical model of bereavement**

A number of theoretical models aim to describe how individuals respond to grief. The dual process model of bereavement suggests that grief work involves individuals oscillating between loss-orientated and restoration-orientated styles of coping (Stroebe & Schut, 1999). The five-stage model of grief posits five stages of grief that individuals work through following the death of someone close (Kubler-Ross, 1969). The five stages occur in no specific order and include denial, anger, bargaining, depression and acceptance (Kubler-Ross, 1969). According to Bowlby's (1961) theory of attachment, grief is a predictable response to death due to the inevitable separation that occurs. A more recent theory extends upon these models and argues that when bereaved people find a place for the deceased in their ongoing lives it is not a denial of their loss, but an opportunity to enrich their daily living (Klass, Silverman & Nickman, 1996). Ultimately, the provision of bereavement support in hospices is more likely to be effective if informed by theoretical models of bereavement. Currently there is no clear theoretical grounding, based on these models, in bereavement support provided by hospices.

### **Types of bereavement support**

The types of bereavement support available, and the way in which hospices deliver it, varies considerably. For example, there may be counselling, support from volunteer befrienders, written information, telephone contact and psychosocial support (Reid et al., 2006). Psychosocial support refers to the psychological and emotional wellbeing and care of family and carers (National Council for Hospice and Specialist Palliative Care Services, 1997). A different form of bereavement support is family focused grief therapy, which begins during the care of a terminally ill patient and continues after the death of that individual, to support family members (Kissane, McKenzie, Bloch, Moskowitz, McKenzie & O'Neill, 2006). Closed bereavement groups are effective in helping people through bereavement (Schneider, 2006) and Yalom (2005) found that being in a group setting was healing in itself. However, methodologically rigorous evaluations of bereavement support provided by hospices is lacking (Parkes, 1996; Forte et al., 2004). Whilst NICE guidelines report on a number of studies that used group work, there is no evidence regarding a particular model of practice and there is little evidence to show the effectiveness of running such groups (Finley & Payne, 2010).

Consequently, there is no 'best practice' model for hospices to follow when delivering bereavement support and we know little about the nature and quality of support provided (Reid et al., 2006). This highlights the importance of empirically assessing bereavement interventions to help determine the impact of bereavement support on the bereaved person (Schut & Stroebe, 2005). It is also important to acknowledge that grief is a natural response to loss and that the majority of people can employ their own resources to adapt (Agnew et al., 2011). Complicated bereavement is diagnosed when a person experiences distress for more than six months. Research into bereavement support should acknowledge that an improvement in grief symptoms may be due to the individual naturally adapting to their loss, rather than as a result of any bereavement support that has been provided. Ultimately randomized controlled trials with a treatment as usual control would be required to fully answer this question.

Hospices are seen as experts in providing bereavement support. However, they have not shared this knowledge in the same way as they have in other areas of expertise, such as pain management (Field, Payne, Relf & Reid, 2007). A literature review would aim to capture and elucidate the type of bereavement support hospices are providing, and share this information with others.

### **Aim of the current review**

The most recent review of bereavement care interventions was carried out in 2004 (Forte, Hill, Pazder & Feudtner, 2004) before the NICE guidelines around bereavement support were produced. The authors concluded that, due to the paucity of controlled clinical trials, it is impossible to make recommendations regarding effective treatments for bereaved people. Five barriers to bereavement care interventions were identified; 1) methodological flaws of study design, 2) few published replication studies, 3) inadequate reporting of intervention procedures, 4) stultifying between-study variation, and 5) excessive theoretical heterogeneity.

The focus of this critical literature review will be to evaluate the extent and quality of research into bereavement support available in hospices. It will seek to ascertain which theories or models of bereavement, if any, hospices draw upon when providing bereavement support. This information will inform recommendations for future clinical work and research.

This focus will be particularly helpful for health care professionals working in hospices, including clinical psychologists, by providing a succinct up to date review of the evidence base.

## **Method**

### **Search strategy**

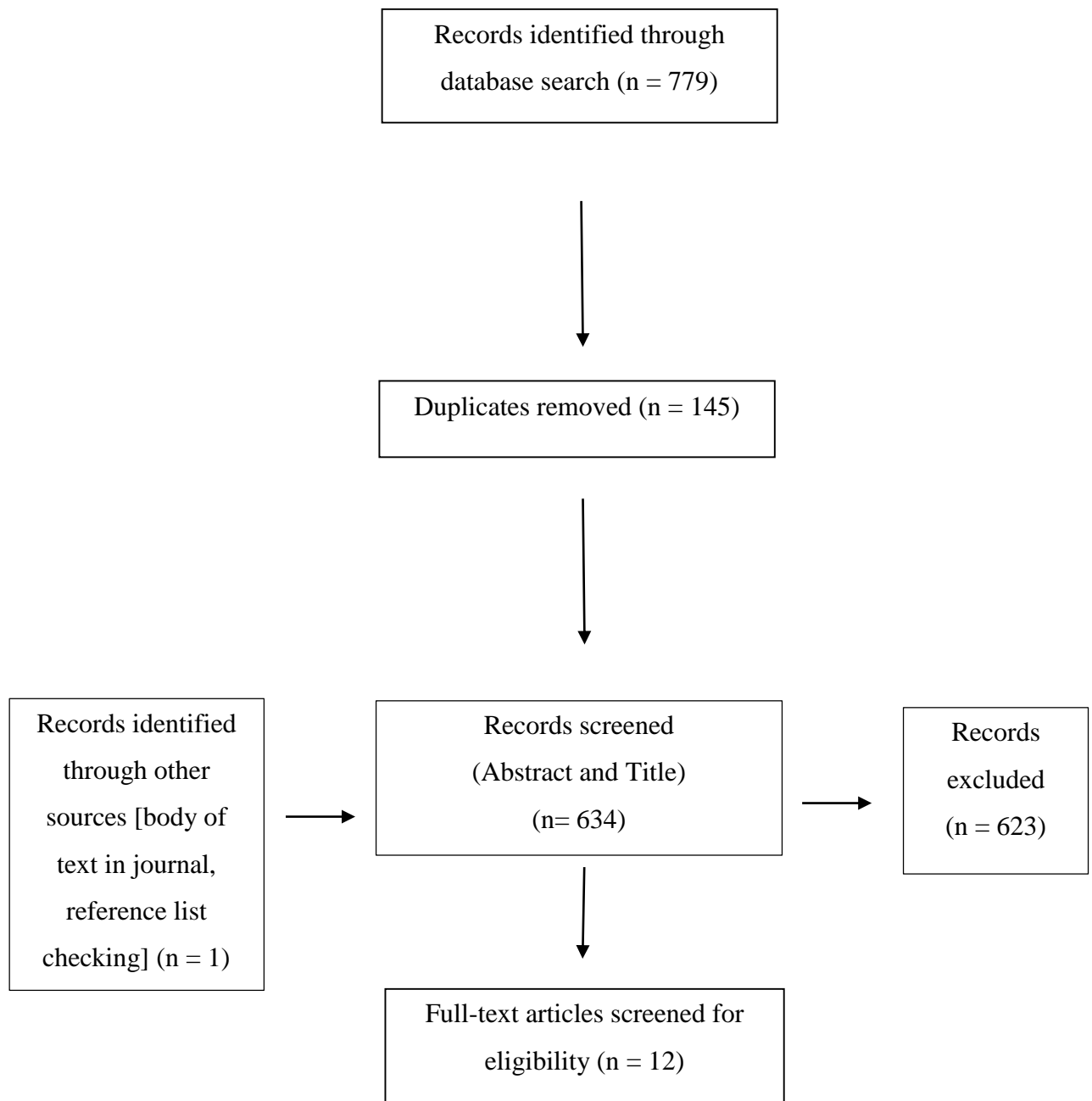
An initial database search was carried out in PubMed, PsychNET, SCOPUS and Cochrane. The date range was restricted to papers published after the last review on this topic (Forte et al., 2004), i.e. from 2004 to 2015. The search strategy was carried out using the following terms (hospice) AND (famil\* OR carers OR death OR bereavement OR grief) AND (support OR counselling OR therapy).

### **Inclusion and Exclusion Criteria**

Each article was screened for inclusion according to the following criteria: the article included (i) post-bereavement support, (ii) provided by a hospice, (iii) based in the UK or Ireland, (iv) was published in a peer-reviewed journal and (v) was published in the English language. Books, conference presentations, letters, symposiums and editorials were excluded from the search.

### Selection of Studies

The initial search yielded 634 results after 145 duplicates were removed. The reference section of the final journals were searched by hand to locate additional relevant journals. Twelve studies met the inclusion criteria (see Figure 1).



**Figure 1:** Flow chart of study selection

### Results

This section will synthesise the key findings from the papers included in this review to help determine the quality of research into bereavement support provided by hospices (see Table 1 for a summary of findings).

The quality of the studies included in this review vary (see Table 2). There has been only one RCT and the other studies are cross-sectional, describing mixed-method studies, postal surveys, retrospective audits and qualitative research. These research papers will be discussed in turn by order of rigour.

### **Randomised Control Trials (RCT)**

#### *Exploratory study*

Only one RCT has examined the effectiveness of bereavement support in hospices. This study evaluated a creative arts support group for bereaved individuals (McGuiness, Finucane & Roberts, 2015). The design of the creative arts bereavement support group was based upon the Dual Process Model (DPM) of bereavement (Stroebe & Schut, 1999). A small number of open-ended questions were asked to elicit participant's views and experiences of attending the bereavement support group. The Adult Attitude to Grief (AAG) scale and Texas Revised Inventory of Grief (TRIG) questionnaire measured the effectiveness of the intervention. The AAG can measure the client's ability to oscillate between loss and restoration-orientated coping, as predicted by the DPM. This is the only study that referred to using a theoretical model to determine what measures should be employed in the research.

A sample size of 20 was utilized for this study. In total, there were ten participants allocated to the art group and ten participants to a waiting list control group. Non parametric tests showed there was no significant difference between the two groups at time two when the clinical group had received the intervention and the control group had not ( $z = -1.94, p = 0.051$ ). However, when the analysis only included participants who had completed six or more sessions there was a significant difference in scores between the clinical and control group ( $z = -2.21, p = 0.02, \eta = 0.6$ ). Nevertheless, the study highlighted that this finding should be interpreted with caution as two of the participant's scores might have influenced this finding. The qualitative data showed that the majority of participants

rated the group as helpful and whilst 14 participants found some aspects of the group difficult, 17 participants stated that their understanding of grief changed.

### *Summary*

This is the only RCT that has examined the effectiveness of bereavement support provided by hospices. The results showed that a creative arts bereavement support group was effective in helping participants oscillate between loss and restoration-orientated coping. However, the findings only provide limited insight into the impact of bereavement support because the study only reviewed one specific type of bereavement support and used a small sample size. These limitations could have potentially reduced the validity of the research and increased the likelihood of a sampling error. The study did not state what method was used to analyse the qualitative data so it is unclear how the data was coded.

### **Cross sectional design**

#### *Mixed-method*

Five cross-sectional mixed method studies explored the type and quality of bereavement support provided by hospices, as described below.

Reid et al. (2006) examined the provision of bereavement support from five different hospice sites using qualitative interviews, focus groups and bereavement outcome measures. At each hospice, there was at least one interview with the bereavement support coordinator. Other staff interviewed included senior management staff, in-patient nurses, health care assistants, ward staff, hospice doctors, day care staff, chaplains, administrative staff and volunteers. Altogether 201 staff members took part in the focus groups or interviews. In addition, 105 bereaved people also took part in the research; 82 people had accessed bereavement services and 23 had not. These bereaved participants completed the Short Form (36) Health Survey (SF36) and Grief Experience Inventory (GEI) after the interviews/focus group and again six months later. However, this data was not analysed due to the small sample of bereaved people who had not accessed bereavement services. This study followed on from a postal survey by Field, Payne, Relf & Reid (2004).

Demographic data showed that the hospices recruited for the research varied in a number of ways demographically and geographically. The number of bereavement support



activities offered by the five hospices ranged from two – four and this included a mixture of social and therapeutic support. It is noteworthy that none of the hospices conducted risk assessments to identify those most in need and instead they relied on people to ‘opt in’ to bereavement support. This is not consistent with the recommendations from NICE guidelines.

One main theme from the interviews with staff and bereaved people was the importance of ensuring that there is continuity between pre and post bereavement support. The interviews also showed that the rationale for offering bereavement support was not always clear amongst staff. The study concluded by highlighting the importance of providing the appropriate level of bereavement support, having a clear rationale for the bereavement support activities offered and the importance of ensuring that there is continuity between pre and post bereavement support. The qualitative results are described in a separate paper (Reid, Field, Payne & Relf, 2006) which identified, via thematic analysis, three types of one-to-one bereavement support. The three types of bereavement support included support from paid bereavement staff, counselling and befriending. The other types of support that were identified included ongoing telephone support, social groups, therapeutic groups, drop-in events, spiritual support, chaplains, anniversary cards and referrals to other agencies. This finding offers an insight into the types of bereavement support that hospices offer. However, the study recognises that this still fails to provide evidence about what is ‘best practice’ for hospice-delivered bereavement support.

Unfortunately, in these research papers the methodology was poorly described making it difficult to replicate this research. It was not clear how the five in-depth organisational case studies were chosen, or how staff members were recruited to take part. The quantitative data could not be meaningfully analysed due to the unequal size of the comparison group. Additionally, the study simply highlighted similarities in bereavement care amongst the different hospices, but failed to evaluate the quality of the support available.

Vale-Taylor (2009) used a mixed-method study design and recruited 43 bereaved people to either complete a self-report questionnaire or take part in a semi-structured interview. The purpose of this was to explore what people did after the loss of a loved one, and why. A focus group was held with bereavement counsellors from the hospice in question. Klass,

Silverman and Nickman's (1996) theory of bereavement was used as a foundation to inform the design of the study, as Vale–Taylor (2009) wanted to expand on this theory and explore how bonds are maintained between the bereaved and the deceased.

The quantitative and qualitative data was analysed as two distinct data sets. Descriptive statistics showed that the bereavement rituals chosen by men tended to be solitary or with close immediate family and friends, whereas the bereavement rituals chosen by women were more community based. The small sample size restricted any meaningful statistical analysis of the quantitative data. Thematic analysis highlighted four main categories; rituals carried out for the deceased, rituals with a direct link to the deceased, rituals in the community and rituals undertaken as an act of remembrance. The hospice events included remembrance services, bereavement counselling and a space for social gathering. However, the results from the thematic analysis showed that informal rituals created by bereaved participants were more important than the planned events that the hospices offered.

Thematic analysis was used to analyse the semi-structured interviews, but the authors did not indicate who transcribed and analysed the data, whether this involved an independent researcher or crosschecking with another researcher to ensure inter-rater reliability. Despite this, the research findings supported Klass et al's. (1996) theory of bereavement as it concluded that rituals were carried out to keep a bond with the deceased. However, there is a lack of empirical evidence to support this claim.

Roberts and McGilloway's (2010) conducted a mixed-method study using postal surveys and one-to-one interviews. In total, 78 people returned the bereavement information evening service questionnaire and 89 people returned the monthly memorial bereavement service questionnaire. Semi-structured interviews were held with eight people who had attended the bereavement information evening or the monthly memorial service and with 14 people who had chosen not to attend. This study used thematic analysis to analyse the qualitative data.

The results from the quantitative and qualitative data were presented together in four sections, which included; reasons for attending the Bereavement Information Evening (BIE), the timing of the BIE, hospice as a venue for the BIE and attenders versus non-

attenders. Quotes were used sporadically to highlight people's feelings about the hospice as a venue for the BIE. Of those recruited to complete the survey, 43 people had attended a BIE and 112 had not. The quantitative data showed that three-quarters of people ( $n = 32/43$ ) who attended a bereavement evening found it helpful. However, the qualitative responses highlighted that attenders varied in their responses about what they specifically found helpful. The research found that BIE attenders scored significantly higher, on part one and two of the TRIG, than non-attenders ( $t(140) = 2.74, p = <.01$ ;  $t(143) = 3.05, p = <.01$ ). This shows that attenders were more distressed than non-attenders were.

Roberts and McGilloway's (2011) paper discusses the methodological and ethical aspects of bereavement support provided by the hospice based on their earlier findings (Roberts & McGilloway's 2008; 2010) and presents further results from phase two of this research. Phase two assessed the impact of a one-to one listening volunteer bereavement support service provided by a hospice. The intervention group consisted of 69 participants who were assessed pre-intervention and then at six months follow-up. A comparison group of 36 bereaved people who had not requested bereavement support were assessed at the same time points. In addition, there were four one-to-one interviews and three focus groups with staff and volunteers delivering the intervention.

At baseline the intervention group scored significantly higher than the matched comparison group on the Hogan Grief Reaction checklist ( $p = 0.00$ ), the Inventory of Complicated Grief ( $p = 0.03$ ) and the Brief Symptom Inventory 18 ( $p = 0.00$ ). Once the intervention group had received a one-to one listening intervention for six months distress was significantly reduced on the Hogan Grief Reaction checklist ( $p < 0.00$ ) and the Inventory of Complicated Grief ( $p = 0.00$ ). The matched comparison group's level of distress remained stable from baseline to follow-up but it was comparable to the intervention group on the Inventory of Complicated Grief, the depression subscale of the Brief Symptom inventory and the subscale despair on the Hogan Grief Reaction Checklist at six-month follow up. However, as the groups were not matched on level of distress at the start of the intervention, it is difficult to establish if the reduction in distress for the intervention group was due to the one-to one listening intervention service. Potential confounding factors were not measured (such as family support, natural recovery or other factors that may have reduced distress). The study does not give any further information about the qualitative data collected.

### *Summary*

Overall, cross-sectional, mixed methods research suggest that bereavement support provided by hospices is helpful. Whilst the research by Reid et al. (2006) and Field et al. (2007) showed that the types of bereavement support provided by hospices vary, Vale-Taylor's (2009) study found personal rituals to be more helpful than the bereavement support provided by hospices. These conclusions should be interpreted with caution as most of the research was carried out retrospectively, three studies lacked an adequate control group for the quantitative work (Reid et al., 2006; Vale-Taylor, 2009; Roberts & McGilloway's, 2011) and only one study used pre and post measures to directly examine the quality and impact of the different bereavement support provided by hospices.

### *Retrospective postal survey*

Two postal surveys explored the type and/or the quality of bereavement support provided by hospices. Roberts and McGilloway's (2008) research utilised a sample of 517 bereaved clients and explored the provision of specific bereavement support provided by one hospice. This included a monthly memorial ceremony, a bereavement information evening and a volunteer bereavement support service. Bereaved clients who had attended the volunteer bereavement support service in the previous two years, or a monthly memorial ceremony and/or the bereavement information evening in the previous 12 months, were invited to take part. The results showed that those who attended the bereavement information evening scored significantly higher on the TRIG, than those who did not, at the time of death and time of study ( $p = 0.007$ , effect size = 0.05;  $p = 0.003$ , effect size = 0.006). The volunteer bereavement support service was not evaluated because there was no appropriate comparison group. For attenders and non-attenders of the monthly memorial ceremony a meaningful comparison of grief symptoms was not conducted because the size of the comparison group (non-attenders) was unequal.

Field et al. (2004) conducted a national postal survey to explore what types of bereavement support hospices and specialist palliative care adult bereavement services offered. They recruited 248 bereavement services, of which three quarters was associated with an inpatient hospice. The remaining bereavement services operated at home or in a hospital but it is unclear who delivered this support. The survey consisted of structured and open-ended questions. The results found that the most common types of support provided were

one-to-one support, phone support, group support, memorial services and the distribution of literature around bereavement. Descriptive statistics showed that 90% of the services offered one-to-one bereavement support and the range of activities offered by each service varied from two to eight. Over a third of services (43%) reported that they used a formal assessment measure to determine level of bereavement support needs. Comparison with bereavement support services provided in the United States (Demmer, 2003), showed that the same forms of support were offered in both countries.

### *Summary*

The quality of the bereavement support in the studies by Field et al. (2004) and Roberts and McGilloway (2008) cannot be properly established as it was not evaluated. Field et al. (2004) only collected data on the type of bereavement support provided, with no information about its efficacy or effectiveness. The administration of a standardised grief measure to those who had received the bereavement support would have helped to assess outcome. Roberts and McGilloway (2008) measured grief reactions retrospectively, rather than directly post-intervention, which restricted accurate measurement of the direct impact of the bereavement support on grief reactions. Furthermore, although Roberts and McGilloway (2008) report a high response rate (83%), responses only reflected the perspective of a single staff member from each service. Therefore, a potential selection bias could limit the reliability of the findings.

### *Retrospective audit*

Finley and Payne (2010) carried out a retrospective evaluation of bereavement support groups provided by hospices. This qualitative study involved reviewing 65 records of groups meetings and 22 evaluation forms completed by group attenders at subsequent reunions. The group facilitator completed a pre-designed questionnaire at the end of each group session. These forms were used to help identify themes that had arisen from the group. Descriptive statistics were used to calculate how frequently a theme occurred and in total 34 themes were recorded. The main themes discussed were 'family life', 'stories of the dying process' and 'loss and loneliness'. The findings showed that the groups were helpful as they provided a space to meet other people, where there could share their feelings.

### *Summary*

The records were analysed by an independent researcher, which helped reduce potential bias. However, only the people who attended the reunions, after the group had finished, completed the evaluation forms. The authors acknowledged that this may have led to a selection bias as only those who were most engaged, were likely to have attended the reunions. Although there were a number of themes identified, there was no indication of the qualitative method used to analyse the data so it is unclear how themes were developed.

### *Qualitative*

McGuinness and Finucane (2011) used a qualitative questionnaire methodology to evaluate a hospice creative arts bereavement support group intervention. At some unspecified point after the eight-week intervention, group participants completed and returned qualitative questionnaires. Regular review meetings were held throughout the delivery of the intervention, with the facilitators and separately with two leads at the hospices. The initial sample size of seven fell to five after two participants dropped out after two sessions. One participant dropped out because they found the group format difficult and another participant dropped out because of a family crisis. Emerging themes found that the group helped to increase confidence, aid emotional expression and provide peer support. This research would be difficult to replicate, as there was no information regarding inclusion and exclusion criteria. The evaluation did not state how the qualitative data was analysed, and who by, which restricted the validity of the findings. It also lacked description of demographic information. However, the researchers concluded that the group was beneficial and this led to the development of a RCT (McGuinness et al., 2015).

Agnew, Mantelow, Haynes and Jones (2011) carried out a qualitative survey across ten Marie Curie hospices in the UK, to examine the provision of bereavement support. The type of bereavement follow-up offered included sending anniversary cards, condolence letters, group support, individual support, memorial events, follow-up contact and giving out a bereavement booklet. The data was analysed using thematic analysis. A sample of the interview transcripts were read by another member of the team, so that the themes could be crosschecked. Any discrepancies identified in the themes were discussed. This method of analysis helped to improve inter-rater reliability. In total, ten Bereavement Service Leads (BSL) took part in the research. The four main themes identified were ‘assessment processes’, ‘timing and level of bereavement follow-up’, ‘ethical issues’ and ‘staff training’. Nine out of the ten hospices used a bereavement checklist at the time of death

and one carried out a bereavement assessment over the telephone. The checklist used by the hospices was based on the theoretical models by Parkes (1993), Stroebe and Schut (1999), and Klass et al. (1996).

Field, Payne, Relf and Reid's (2007) study considers some of the issues identified with the provision of bereavement support, provided by hospices, identified from earlier mixed-methods studies (Field et al., 2004; Reid et al., 2006). Two main issues raised in this paper were that bereavement support services in hospices have developed idiosyncratically and that hospices have not shared their expertise in providing bereavement support with other services (Field et al., 2007). Therefore, hospice's expertise in bereavement support is referred to as an unrecognised and under-utilised resource (Field et al., 2007).

### *Summary*

The aims of the qualitative studies were different, with some comparing the types of bereavement support available and others exploring why certain bereavement support was selected by bereaved people. However, they all offered some insight into what types of bereavement support are available in. These qualitative studies provide evidence for the importance of providing such bereavement support. Ultimately, whilst the studies by McGuiness and Finucane (2011) and Agnew et al. (2011) included a small sample size, their results led to successful outcomes; a RCT and the development of a social model of bereavement.

Table 1 - Summary of studies reviewed

<b>Study</b>	<b>Type of study and grading*</b>	<b>Sample</b>	<b>Delay between bereavement and intervention</b>	<b>Measures</b>	<b>Results</b>
Agnew, Manktelow, Haynes and Jones (2011)	Qualitative study IV	10 bereavement support leaders	n/a	Semi – Structured interviews	Four main themes were identified as central to hospices providing bereavement support. 1) Assessment process, 2) timing and level of bereavement follow-up, 3) ethical issues, 4) staff training.
Field, Reid, Payne and Relf (2004)	Retrospective postal survey IV	248 adult bereavement services (one staff member responded from each service)	n/a	Postal survey using questionnaire with structured and open ended questions	83% response rate. One-to-one support, phone support, group support, memorial services and the distribution of literature around bereavement are the most common types of support provided by hospices.



Field, Payne, Relf and Reid (2007)	Qualitative study IV	5 hospices paid and voluntary staff (nurses, social workers, counsellors, chaplains, doctors, psychologists, psychiatrists, volunteers and administrative and clerical staff).	n/a	Semi-structured interviews and focus groups	Bereavement support provided by hospices is often developed independently and often based on unexamined assumptions.
Finley and Payne (2010)	Retrospective audit IIC	10 groups attended by 70 bereaved people	6 months after loss	A retrospective audit	34 themes were identified in the records. The main themes identified were family life, stories of the dying process and loss and loneliness.
McGuiness and Finucane (2011)	Qualitative study IIC	5 bereaved participants	Not stated	Qualitative methods using customised questionnaires and review meetings	The bereavement support group was found to help increase confidence, aid emotional expression and provide peer support.

McGuiness, Finucane and Roberts (2015)	RCT IC	10 bereaved clients in the arts group 10 bereaved clients in the waiting list control	Not stated	AAG and TRIG	Non parametric tests showed no significant difference between the two groups at time two when the clinical group had received the intervention and the control group had not ( $z = -1.94$ , $p = 0.051$ ). When the analysis only included participants who had completed 6 or more sessions there was a significant difference in scores between the clinical and control group ( $z = -2.21$ , $p = 0.02$ , $\eta = 0.6$ ).
Reid, Field, Payne and Relf (2006)	Cross- sectional mixed-method IV	5 hospices Paid and voluntary hospice staff (bereavement support coordinators, senior managers, nurses, ward staff, health care assistants, chaplains,	n/a	Semi-structured Interviews and focus groups	The bereavement support offered included one- to-one support, counselling, befriending, ongoing telephone support, groups, drop-in events, spiritual support, anniversary cards and referrals to other agencies.

		administrative staff and volunteers).			
Reid, Field, Payne and Relf (2006)	Cross-sectional mixed-method IV	248 hospices (one staff member responded from each service - bereavement support coordinators, senior managers, nurses, ward staff, health care assistants, chaplains, administrative staff and volunteers). 105 bereaved people	Not stated	SF (36) GEI	Hospices need to address the issue of providing appropriate level of bereavement support and the rational for providing particular types of bereavement support should be made clear.
Roberts and McGilloway (2011)	Cross-sectional mixed-method IIIB	69 bereaved clients who had accessed a one-to-one listening service	Not stated	Hogan Grief Reaction Checklist, the Inventory of Complicated Grief,	The overall levels of distress reduced significantly in the intervention group (Hogan Grief Reaction Checklist $p < 0.00$ ,

		Comparison group: 36 bereaved people who had not received any support		Brief Symptom Inventory	Inventory of Complicated grief, $p = 0.00$ ).
Roberts and McGilloway (2008)	Retrospective postal survey IV	517 bereaved clients	12- 24 months	MMC BSQ BIE BSQ VBSS BSQ TRIG SCSORF	Those who attended the bereavement information evening, when compared with non-attenders, reported significantly higher levels of grief symptoms on the TRIG, both at the time of death and at the time of study ( $p= 0.007$ , effect size=0.05; $p=0.003$ , effect size = 0.006).
Roberts and McGilloway (2010)	Cross-sectional mixed-method IV	167 bereaved clients	Friends and family who experienced a loss in the previous 10 months	MMC BSQ BIE BSQ TRIG Semi-structured interviews	The qualitative information this research elaborated on Robert's and McGilloway's (2008) quantitative research and found that three-quarters of people ( $n=32/43$ ) who attended a bereavement evening, found it helpful.

Vale-Taylor (2009)	Cross-sectional mixed-method IV	43 bereaved participants	12 - 24 months	Self – report questionnaire and semi-structure interviews	Peoples own individual bereavement rituals were more important than the bereavement events the hospice could offer, which included remembrance services, bereavement counselling and a space for social gatherings.
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Note. AAG = The Adult Attitude to Grief; TRIG = Texas Revised Inventory of Grief; SF 36 = Short Form (36) Health Survey; GEI = Grief Experience Inventory; MMC BSQ = Monthly Memorial Ceremony Bereavement Service Questionnaire; BIE BSQ = Bereavement Information Evening; VBSS BSQ = Volunteer Bereavement Support Service; SCSORF = The Santa Clara Strength of Religious Faith

\* To remain consistent with similar reviews carried out in this area, the evidence was graded according to the rigour of study design and analysis. This was done using the graded system from the Cancer Guidance Subgroup of the Clinical Guidance Outcome Group. Improving outcomes in breast cancer- the research evidence (see Table 2).

Table 2 - Grading criteria for review of carer intervention studies (Department of Health, 1996).

<b>Grade I (Strong evidence)</b>  RCTs or review of RCTs	IA Calculation of sample size and accurate standard definition of appropriate outcome variables IB Accurate and standard definition of appropriate outcome variables IC Neither of the above.
<b>Grade II (Fairly strong evidence)</b> Prospective study with a comparison group (non-randomised controlled trial, good observational study or retrospective study that controls effectively for confounding variables).	IIA Calculation of sample size and accurate, standard definition of appropriate outcome variables and adjustment for the effects of important confounding variables IIB One or more of the above
<b>Grade III (Weaker evidence)</b>  Retrospective or observational studies	IIIA Comparison group, calculation of sample size, accurate and standard definition of appropriate outcome variables IIIB Two or more of the above IIIC None of these.
<b>Grade IV (Weak evidence)</b>	Cross-sectional study, Delphi exercise, consensus of experts.

## **Discussion**

This review has summarised and synthesised the research into bereavement support provided by hospices in the UK and Ireland since 2004. Unfortunately, the studies reviewed show little evidence for the effectiveness of providing specific types of bereavement support in hospices. There are significant limitations in terms of the amount, quality and rigour of the studies conducted. This restricts the development of evidence-based conclusions and limits our understanding of the efficacy and benefits provided by specific types of bereavement support.

The lack of controlled clinical trials and methodological flaws of the studies design echo the earlier findings of Forte et al's. (2004) literature review into bereavement support. This concluded that the paucity of rigorous controlled clinical trials makes it impossible to make evidence base recommendations regarding the treatment of bereaved people. However, since 2004, there have been some positive developments in this area. First, there has been more research in bereavement support provided specifically by hospices. Second, this review provides a novel focus on the types of psychosocial bereavement support options provided specifically by hospices. This has helped develop our understanding of bereavement support provided in this particular area. Third, hospices are becoming recognised as experts in providing bereavement support.

### **Type and quality of bereavement support**

The bereavement support offered in the studies varied widely from telephone support to one-to-one listening. However, the studies did not specify how researchers chose the bereavement support options offered to participants. This is not in line with NICE (2004) guidelines, which state that hospices should be routinely conducting individual risk assessments to determine appropriate level of bereavement needs.

The majority of studies failed to use standardised grief measures pre and post intervention. This approach would have helped assess the impact of the different types of bereavement support on people's grief reactions and/or quality of life. Without this evaluation, it is difficult to assess the impact of providing one particular type of bereavement support over another, or even over no support. Furthermore, it is impossible to develop evidence-based

conclusions around providing specific types of bereavement support in hospices when there is only one rigorous controlled clinical trial.

### **Methodological issues**

In most of these studies, the methodology was insufficiently described to permit replication with the use of vague descriptions regarding recruitment methods and data analysis, and unclear reporting of findings. According to the grading criteria, (see Table 2) only the RCT could be graded at IC (strong evidence). All the other studies were graded at level III and IV (weak evidence).

A cross-sectional design was employed in 11 of the studies. This only allowed the researchers to measure the impact of bereavement support at one point in time, which restricted measurement around the long-term impact of bereavement support on grief reactions. Furthermore, any significant findings, such as those in McGuinness et al's. (2015) study may simply indicate correlation rather than causation. The descriptive nature of these cross-sectional studies meant they could not evaluate the specific impact of bereavement support on a person's grief response to bereavement.

The majority of studies used descriptive statistics to analyse the data. This type of analysis is unable to offer measurement of statistical significance and power, and so cannot provide evidence around the impact and quality of bereavement support currently provided in hospices. The lack of rigorous research in this area since 2004 is disappointing given that hospices are regarded as experts in providing bereavement support. This critical review shows that hospices are providing bereavement support. However, the research studies do not adequately assess how effective the bereavement support is due to the poor research design employed.

### *Measures*

Across the quantitative and mixed method studies, five different grief measures were used to assess the impact of bereavement support on grief responses. Three of these measures were identified, in Agnew's et al. (2010) critical review of assessment measures, as appropriate measures to determine a person's level of bereavement needs. Selecting evidence-based measures to assess bereavement response is a strength of these studies as it increases the quality of the study design. Two studies (Reid et al, 2006; Roberts &



McGilloway, 2011) used a measure that was not included in the review. Future research should refer to Agnew et al's (2010) review to help inform the selection of an appropriate measure. This will help ensure that future research is using measures that are evidence based.

#### *Control group and Sample size*

In three studies (Reid et al, 2006; Vale-Taylor, 2009; Roberts & McGilloway, 2008) it was not possible to conduct a comparative analysis because in all cases the control group was too small to make meaningful comparisons. The RCT also employed a small sample size. This would have increased the chance of sampling error and reduced the statistical power to identify true differences. The RCT did not include a power analysis so it is impossible to comment on whether the study was powered sufficiently. For the qualitative studies, the sample size was appropriately smaller.

#### *Qualitative studies*

In total, ten studies used some form of qualitative method to collect data. Thematic analysis was used to analyse qualitative information in six studies and content analysis was used in one study. A further three studies (Finley & Payne, 2010; McGuinness & Finucane, 2011; McGuinness et al., 2015) describe a general qualitative analysis but did not state what specific method was used to analyse the data. The development and description of themes identified in the studies were not always explicit and the evidence to support any themes was often lacking. It would have been useful if the research had used more quotes to help substantiate the results and discussion section. This evidence would help either design further research or justify the delivery of particular types of bereavement support.

#### **Theoretical issues**

Three dominant theories from a psychological framework informed either the bereavement support offered, the design of the study or the selection of measures. Agnew et al. (2011) refers to a model of bereavement for informing staff training around bereavement needs assessments and providing adequate bereavement support. A further four papers (Field et al., 2007; Reid et al., 2006, McGuinness & Finucane, 2011 and McGuinness et al., 2015) refer to the use of a model of bereavement for informing the bereavement support that is provided by the hospices. The reference to theories and models of bereavement is a major

strength of these studies as such models help develop our understanding around the bereavement process, which enable us to provide targeted interventions.

It is unclear how the provision of bereavement support provided by other hospices was chosen. The lack of theoretical framework used to inform the delivery of bereavement support in hospices might impact on the quality of support that is provided. Furthermore, if the theoretical underpinnings of providing bereavement support in hospices is unclear then the hospice will not have a framework for informing the measurement of the impact of the bereavement support. This is likely to affect the way that the provision of bereavement support is provided and measured, if at all.

### **Limitations of this review**

There were three main limitations to this review. First, the studies included in this review were assessed for inclusion by the first author only. Second, whilst it was helpful to use the grading criteria for review of carer intervention studies (Department of Health, 1996), it only allowed basic comparisons of the studies. However, this grading system helpfully accounted for both qualitative and quantitative research designs. Third, the review was focused on general bereavement support provided by hospices. However, in the studies reviewed, complex bereavement was not assessed so it is impossible to know whether any of the samples recruited were experiencing complex bereavement.

### **Clinical Implications**

This review highlighted the different types of bereavement support provided by hospices in UK and Ireland. This might be particularly helpful for hospices who are looking to improve, develop or implement a bereavement service and wish to base their delivery on the best available evidence. More specifically, this review should help enable hospices to provide a more unified approach to bereavement support by highlighting the importance of conducting a bereavement needs risk assessment before deciding what bereavement support should be given.

However, the evidence for providing certain types of bereavement support is based on a poor quality of studies, which make inconsistent reference to theoretical models. This limits the evidence base that can be drawn upon when working in hospices and therefore any recommendations for clinical practice should be given with caution. To help develop

this evidence base, hospices should be encouraged to evaluate and audit the bereavement support they provide.

Where possible hospices should draw on existing theory and use evidence based models of bereavement support, such as the bereavement support service model developed by Agnew et al. (2011), so they have a clear rationale for the support they offer. This is particularly important when the evidence for the efficacy of specific treatments is so limited.

Delivering evidence based bereavement support, such as the creative arts group designed by McGuinness et al. (2015), would help ensure that people are receiving the appropriate level of bereavement support in line with the NICE guidelines. However, knowledge in this area is developing and this critical review can act as a catalyst to consider how more rigorous research could evaluate the efficacy of different types of bereavement support in hospices.

### **Future directions for hospice research**

Based on this review, it is difficult to ascertain the overall quality of the bereavement support provided by hospices. Further research in this area is required to measure this adequately. Future research should recognize how methodological weaknesses in previous studies have limited our ability to draw strong conclusions and offer clinical guidance to hospices. There is a critical need to develop rigorous research protocols to test out some of the emerging evidence for bereavement support.

A large scale RCT, with an appropriately matched control group, would help distinguish between the effectiveness of different types of bereavement support. This review has identified evidence suggesting the need to develop a future RCT. This could compare a creative arts group's intervention, based on the DPM of bereavement, with a one-to-one intervention, such as counselling, with a waiting list control group. Outcomes from such a study could help tease apart the impact of the different types of bereavement support available. Rigorous research in this area is critical to ensure that hospices deliver bereavement support that is evidence based and that has proven effectiveness in helping individuals deal with their grief reactions.

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## **An evaluation of ‘suicide risk training’ for General Practitioners**

Emma Smith

Doctoral Programme in Clinical Psychology, Department of Psychology, University of Bath, Claverton Down, Bath, BA2 7AY, Tel: 01225 385506, Email: [es600@bath.ac.uk](mailto:es600@bath.ac.uk)

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Internal supervisor: Dr James Gregory

External supervisor: Dr Rosa Hoshi

Proposed Journal: *BMJ Quality & Safety* (word count: 3,000 - 4,000)

(see Appendix B)

This journal was chosen as it is focused on improving the quality and safety of health care with the overall aim of improving patient care.



## **Abstract**

*Objective:* In the UK suicide rates have been increasing since 2008. The aim of this study was to evaluate the suicide risk training provided by LIFT psychology to GPs. *Method:* All 145 GPs in Swindon were asked to complete a brief questionnaire about their experience of the suicide risk training provided by LIFT psychology. The questionnaire was completed by seven GPs who had done the training and by 23 GPs who had not done the training.

*Results:* The GPs who took part in the suicide risk training reported it as helpful. However 91% of GPs who did not complete the training reported that they were not given the option to take part. *Conclusion:* GPs reported that the suicide risk training was useful but it is currently only offered on an ad-hoc basis which is not in line with the evidence base.

*Recommendations:* For LIFT psychology to create a system for monitoring which GPs take part in the training, to evaluate the training on a frequent basis and to ensure that training is delivered in line with the evidence base.

## **Summary of the literature**

According to the Office for National Statistics (ONS) there has been a gradual increase in suicide rates since 2008 (ONS, 2015). The latest figures show that in 2013, over 6,000 people committed suicide in the UK (ONS, 2015). In 2013 male suicide rates were three times higher than female suicide rates and the highest rate was amongst men aged 45-59 (ONS, 2015). There is a growing body of literature that explores suicide risk factors (Rudd, 2003; Hawton, Comabella, Haw & Saunders, 2013; Tucker, Crowley, Davidson & Guttierrez, 2015). This includes the importance of making a distinction between risk factors (e.g. hopelessness) and warning signs (e.g. behaviour such as buying a weapon). The Cross Government Strategy “Preventing suicide in England” (DoH, 2012) has also recognised that national action is needed to prevent suicide.

The Skills-based Training on Risk Management (STORM) is a suicide prevention training programme that is recommended by the Department of Health for all mental health practitioners (DoH, 2007). Such training is important for these professionals as a large number of people who commit suicide have a mental health problem (Cavanagh, Carson, Sharpe & Lawrie, 2003). Suicide prevention training may be particularly important for GPs because research has shown that on average 45% of people who commit suicide have contact with a primary care service within one month of suicide (Luoma, Martin & Pearson, 2002). However, the assessment of suicide risk amongst patients in primary care settings is low (Schulberg, Bruce, Lee, Williams & Dietrich, 2004; Bryan, Corso, Rudd & Cordero, 2008).

A survey revealed that primary care practitioners who felt more competent to work with suicidal patients were more willing to assess suicidality (Graham, Rudd & Bryan, 2011). Reasons for GPs not screening for suicidal ideation included time pressures and concerns about the impact it could have on a patient’s mental health (Bajaj, Borreani, Ghosh, Patel & Joseph, 2008). Another barrier to screening for suicide risk was cultural issues which included difficulties in asking sensitive questions through an interpreter and uncertainty about cultural attitudes in some ethnic minority groups (Bajaj et al, 2008). Despite this GPs recognise the importance of screening for suicidal ideation as they believe it can help assess and manage risk (Bajaj et al, 2008). A subsequent randomized control trial has shown that screening for suicidal ideation in patients with symptoms of depression does not induce feelings about life not being worth living (Crawford et al., 2011). Other

research has highlighted the importance of GPs having training on the drugs most often used in fatal overdoses to help to reduce suicide (Gunnel & Frankel, 1994).

The Cross Government Strategy “Preventing suicide in England” (DoH, 2012) highlighted the importance of strengthening the mental health training that GPs receive. This is further supported by the Royal College of GPs (RCGP) who stated that part of a GPs training will now involve identifying suicide risk (RCGP, 2014). This is important as a large proportion of qualified GPs have not undergone risk assessment training (Bajaj et al., 2008).

According to the Department of Health (2007) risk training should be provided to all staff involved in risk management every three years. Therefore, to implement best practice qualified GPs should have completed some form of suicide risk training within any three year period. Furthermore the importance of suicide risk training implementation is supported by Gask, Dixon, Morriss, Appleby and Green (2006) who highlighted that the evaluation of suicide risk training is scarce.

### **Local Service Focus**

A suicide audit has been carried out regularly by Swindon’s Public Health Department since 2009. The most recent audit showed a consistent increase in suicides rates since 2005 (Weld & Mayes, 2014). It also showed that unemployment has increased in Swindon and this has been identified as one of the risk factors for committing suicide (Barr, Taylor-Robinson, Scott-Samuel, McKee & Stuckler, 2012). Consistent with the evidence base, the audit found that it is common for people to have had contact with their GP in the 12 months leading up to their suicide. The findings from this audit, combined with the national suicide prevention strategy, “Preventing suicide in England” (2012), are used to inform a local suicide prevention strategy. Since the strategy was set up a number of initiatives have been developed. This includes the delivery of Mental Health First Aid training to those who work with high risk groups, by an independent organisation, and the sharing of information about risk factors from the Samaritans to agencies such as the Job Centre. Future work will involve Public Health liaising with various services to help increase communication and knowledge of risk factors for suicide. One of the main recommendations from this local strategy is that people who work with high risk groups should have access to appropriate training on suicide risk. LIFT psychology, a primary care mental health service who work closely with GP surgeries, provide suicide risk training to GPs in the Swindon locality. LIFT psychology have developed their own

suicide risk assessment pack and have offered training to all GP surgeries to ensure correct implementation. The suicide risk training was provided by staff members from LIFT psychology to GPs. The training was delivered in house on a number of different occasions. The training included information on how to complete a risk assessment form, guidance on the use of a risk flow chart to determine level of risk and a keeping safe leaflet to use with patients who are at risk. The aim of the training was to help GPs become aware of the indicators of risk and to help them ascertain whether someone is low, medium or high risk.

The suicide risk training, provided by LIFT psychology to GPs, was rolled out in July 2014. All 30 GP surgeries in Swindon were contacted regarding the suicide risk training and 11 took part.

Whilst all the GP surgeries in Swindon were offered suicide risk training, only 50% agreed to take part. There is no record of how many GPs have been trained and no evaluation of the training has been undertaken.

### **Aims**

This aims of the present study are to discover the usefulness of the suicide risk training programme provided by LIFT psychology by investigating the following three questions:

- 1) Why did 50% of GP surgeries decline the suicide risk training?
- 2) How helpful, in practice, has the suicide risk training been for those GPs who have taken part?
- 3) What changes could be made to improve the suicide risk training?

### **Method**

#### ***Participants***

In total 15 GP surgeries out of 29 agreed to take part in the research. 7 GP surgeries did not want to take part because of either time constraints or because they felt that too much time had lapsed since completing training and therefore they did not think that they could contribute much to a questionnaire. The remaining 7 GP surgeries had initially agreed to

take part in the research but then opted out of the research as they did not have time to fill in the questionnaires.

Out of 145 GPs from 29 surgeries, 30 GPs from 15 GP surgeries took part in the research. Due to restricted access to contact the GPs directly, recruitment was facilitated via the practice manager of each surgery who was contacted by telephone or email.

Data was collected over 4 months and in total 30 questionnaires were returned. Twenty-three (77%) of the questionnaires were completed by GPs who had not received the suicide risk training and 7 (23%) questionnaires were completed by GPs who had. One questionnaire was completed by a nurse practitioner and this has been excluded from the analyses as the project is focused on the evidence base around GP suicide risk training.

### **Measures**

A questionnaire was developed to evaluate the suicide risk training (see Appendix C). A GP was consulted in the development of the measure and it was recommended that the questionnaire be kept brief, one page maximum with multiple choice options to encourage participation and acknowledge GPs time restrictions. Subsequently the design of the questionnaire was considered in terms of the time pressures that GPs have to fill in such forms. The questions included were informed by the literature, national policy documentation and input from staff members at LIFT psychology who provided the suicide risk training.

The questionnaire was split into two parts. The first part of the questionnaire (questions 1-7) was targeted towards GPs who had not completed the training and was designed to answer question 1 of the study aims. The second part of the questionnaire (questions 8-18) was targeted towards the GPs who had completed the suicide risk training and was designed to answer question 2 and 3 of the study aims.

### **Design**

Adopting a cross sectional design, GPs were asked to fill in a short questionnaire about suicide risk training.

### **Procedure**

The practice manager of each surgery was informed of the service improvement project over the phone or email. If the practice manager agreed to take part in the study then a pack of questionnaires were sent via post. GPs were given a participant information sheet (see Appendix D) to read. This detailed the nature of the service improvement project. They were also given a consent form to sign (see Appendix E) before completing and returning the questionnaires. If the questionnaires were not completed within a 2-4 week time period then the practice manager was contacted by telephone to remind them about the questionnaires and in 7 cases, to find out why the GPs had declined to take part.

## **Results**

The data from the questionnaires has been split into three parts to help address the study aims:

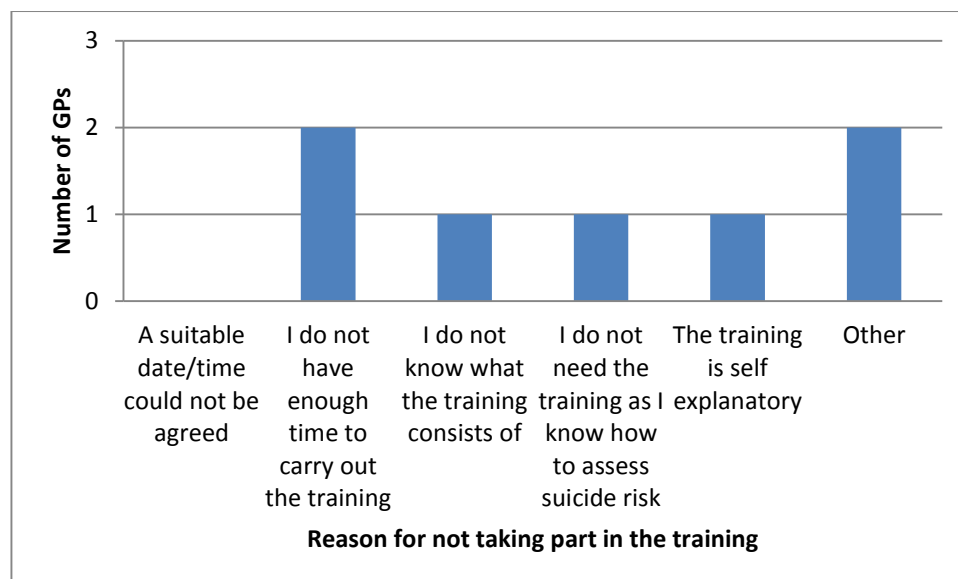
### *Part 1) why did 50% of GP surgeries decline the suicide risk training?*

There was a discrepancy between the records that LIFT psychology kept on how many GP surgeries took part in the training (n=11) and how many individual GP surgeries reported that they took part when I completed the evaluation (n=15). The reasons for this were not investigated. It may be that records kept by LIFT psychology had not been updated accurately or that some GP practices may have mistakenly stated that they took part when they did not.

Of the GPs who took part in this study, 77% (n=23) reported that they had not received LIFT's suicide risk training and 23% (n=7) reported they had. Of the 77% (n=23) of GPs who had not taken up the training, only 4% (n=1) reported that they were aware of the training but not taken up the offer. The remaining 91%<sup>1</sup> (n=21) reported that they were not aware of the training. The reasons for GPs not accepting the suicide risk training are identified in the Figure 1 below.

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<sup>1</sup> Incomplete percentages indicate missing data



**Figure 1:** Graph to show the reasons for GPs not completing the suicide risk training

Although only 4% (n=1) of GPs said they were offered the training and did not accept it, a total of 17% (n=4) of GPs who did not take part in the training gave reasons for not taking part in the training. This included not having enough time, not knowing what the training consisted of, not needing the training and thinking that the training is self-explanatory. Other reasons included a GP who stated “one of my training needs. Need to work to priorities” (Figure 1).



**Figure 2:** Graph to show the reasons for GPs accepting the suicide risk training

The 23% (n=7) of GPs who took part in the suicide risk training reported that the main reasons for accepting the training was to learn how to manage risk and because the practice manager recommended it (Figure 2).

Of those GPs who had not completed the suicide risk training, 76% (n = 17) had not had any other form of suicide risk training in the last three years. The remaining 18%<sup>2</sup> (n=4) of GPs who had not completed the training had completed other types of suicide risk training listed below:

- Post graduate mental health assessment
- Online mental health training
- Review in surgery of patients with practice team
- Counselling training at Gloucestershire College and training from Swindon and Wiltshire Alcohol and Drugs advisory Service (SWADS) for volunteers
- GWH – Psychiatry Education GP course

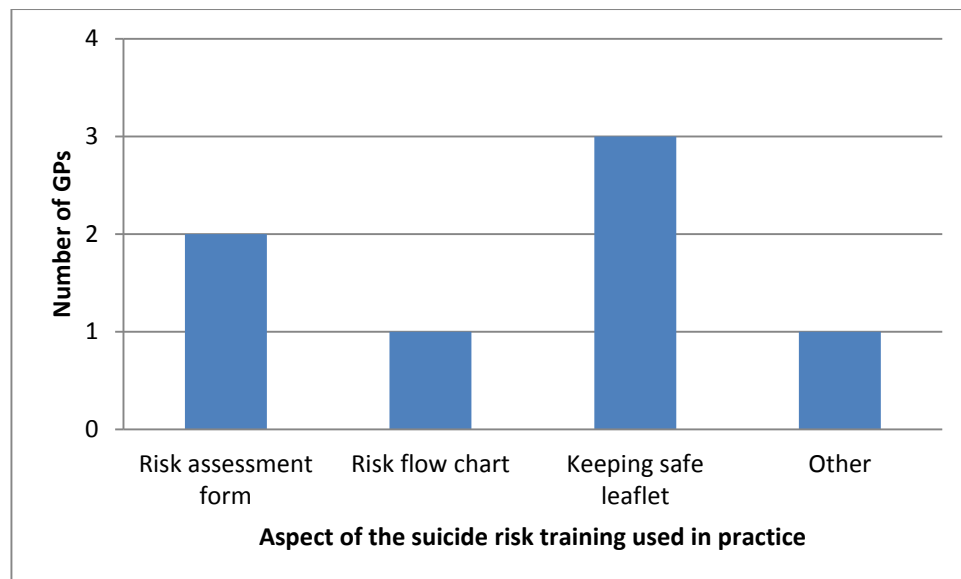
*Part 2 – How helpful, in practice, has the suicide risk training been for those GPs who have taken part?*

On average, the GPs who took part in the training rated the training at 6/10 on a Likert scale which demonstrates the usefulness of the training but also shows a gap for improvement. Out of this sample, 71% (n=5) of GPs reported that the training equipped them with the knowledge to differentiate between low, medium and high risk. All 23 GPs (100%) who completed the training reported that they were aware of the indicators of risk and none of these GPs reported any aspect of the training as unclear. Out of the GPs who took part in the training 100% (n=23) reported it to be targeted at an appropriate level and none of the GPs stated that they required any additional training.

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<sup>2</sup> Incomplete percentages indicate missing data





**Figure 3:** Graph to show what aspects of the suicide risk training are used in practice

In practice, all three aspects of the suicide risk training are used by GPs. The keeping safe leaflet appears to be the most frequently used. The column ‘other’ was described by one GP as a ‘full clinical assessment’.

*Part 3) what changes could be made to improve the suicide risk training?*

Whilst 86% (n=6) of GPs felt that suicide risk training equipped them with the skills necessary to carry out suicide risk assessments confidently, 14% (n=1) of GPs stated there were aspects of the suicide risk assessments that were unclear. These GPs did not provide any responses to questions about what was unclear or how the suicide risk training could be improved.

There were 7 (30%) GPs who took part in the training and listed further training areas regarding suicide risk that they would benefit from. These are listed below:

- “use of tool”
- “yes – I seem to find it a more and more difficult subject...with a contradiction between empathy and persuasion”
- “any latest changes, please update, thanks”
- “Acceptance and guidance re: secondary care acceptance criteria”
- “Any training would be beneficial”
- “Acute management and available referral pathway”

- “Some review of evidence based approach to suicide assessment”

## **Discussion**

The purpose of this study was to evaluate the suicide risk training provided by LIFT psychology to GPs. This study collected feedback from GPs in the form of questionnaires to help answer the following questions which will each be individually addressed below:

- 1) Why did 50% of GP surgeries decline the suicide risk training?
- 2) How helpful, in practice, has the suicide risk training been for those GPs who have taken part?
- 3) What changes could be made to improve the suicide risk training?

### **1. Why did 50% of GPs surgeries decline the suicide risk training?**

Out of the 15 GP surgeries that were recruited for this study, 5 GP surgeries had completed the suicide risk training and 10 GP surgeries had not. Out of these 10 GP surgeries, 23 GPs (77%) reported that they had not completed the suicide risk training and only 1 GP (4%) reported that they had been offered the training and declined because they did not know what the training consisted of and because they “need to work to priorities”. This suggests that 9 GP surgeries were not offered training. This data does not correspond with the information from LIFT psychology which stated that 50% of GP surgeries had declined the suicide risk training. There could be a number of reasons for this discrepancy. First, GP staff turnover could have resulted in some GPs not being offered the training because they did not work for the service at the time or have since left. This would mean that this study was unable to capture the experience of the GPs who had been offered training but declined it. Second, when the surgery was contacted about the training, the practice manager may have not made the training explicit so GPs may have said no and not remembered. Third, the GPs who were offered the training, but declined to take part, may have chosen not to take part in this study.

In total 74% (n=17) of GPs who participated in this study had not had any form of suicide risk training in the last three years. This finding is consistent with other research (Bajaj et al., 2008) that found a large proportion of GPs had not had suicide risk training. This undermines the recommendation from DoH (2007) which states that GPs should have suicide risk training every three years. Interestingly, 61% (n=14) of GPs who had not

undergone the suicide risk training said they would like to take part. This suggests that the option for suicide risk training might not been given to GPs or that the details regarding the training might have been lost in communication between LIFT, the practice manager and GPs. A lack of suicide risk training for GPs may have implications for how GPs assess, monitor and respond to patients identified at risk. In a worst case scenario, poor clinical governance around GPs suicide risk training could impact negatively on rates of suicide. Research by Luoma et al. (2002) has shown that 45% of people who commit suicide have contact with a primary care service within one month of suicide which highlights the importance of GPs feeling confident to assess risk adequately.

## **2. How helpful, in practice, has the suicide risk training been for those GPs who have taken part?**

The GPs who took part in this study have reported that the suicide training they have been given by LIFT has been well received. This study showed that the 7 GPs who had completed the training were made aware of the indicators of risk. Furthermore, all the GPs reported that the suicide risk training was targeted at an appropriate level and they found it to be clear. This is reflected in the response to question 17, in which 100% (n=23) of GPs responded that they did not feel they required additional training. However, this outcome is based solely on self-reports from GPs and it is difficult to assess if GPs actually require any further training as there is no objective checklist to determine if GPs are receiving the information and skills they should from the suicide risk training that LIFT psychology provide. This information is vital for ensuring adequate assessment of suicide risk which has been highlighted as an important task by the Cross Government Strategy “Preventing suicide in England” (2012).

## **3. What changes could be made to improve the suicide risk training?**

The data showed that one GP (14%) who took part in the training felt there were aspects that they were unsure about in regards to suicide risk assessments. However none of these GPs specified how it could be improved or what they were unsure about which restricts how much these responses can be interpreted and responded to. There were seven GPs who completed the training and said there was specific suicide risk training that they would benefit from. This included more information regarding “acceptance and guidance re: secondary care acceptance criteria” and the “acute management and available referral

pathway". Another GP stated that they would like a "review of the evidence based approach to suicide risk assessment". Currently these topics are not covered in the suicide risk training that LIFT psychology provide. One GP stated that they would like some training around the "use of the tool" which LIFT psychology currently offer in their training programme. Whilst this information is helpful to feedback back to LIFT psychology, the responses are limited and they detail specific needs for individual GPs. Thematic analysis was not completed on this data as it was agreed that it would not have added anything meaningful to the findings due to the restricted responses from GPs.

The results from the questionnaire has shown that the suicide risk training was reported as useful by the GPs who took part. However, there is no structure in place to measure the effectiveness of the training once it has been completed. The adapted questionnaire used to conduct this research could be used at future training sessions to measure outcomes immediately after training. This will give staff members at LIFT psychology a framework for monitoring the value of this training and for ensuring that it is being implemented effectively. Pre and post measures could also be used to truly measure the effectiveness of any suicide risk training delivered to GPs. The importance of using evaluation to ensure correct implementation has been highlighted by Gask et al. (2006).

The current system for recording training only monitors which GP surgeries take part in the training. This is no system for monitoring which individual GPs take part. This would help monitor which GPs are receiving suicide risk, every three years, as recommended by DoH (2007). This study has highlighted that the practice managers are best placed for monitoring this as they are aware of the staff turnover. A simple data base which records who has completed the training and when it is next due would help regulate this. Suicide risk training should also become part of a GPs mandatory training to help ensure that they complete it.

It is important to highlight that the training was, on average, 20 minutes long. This may be appealing for GPs working under time constraints. However, it is important to ensure that this small time frame does not impact on the quality of training due to the high levels of attendance in GP practices before committing suicide (Luoma et al., 2002) and the different barriers to addressing suicide risk (Bajaj et al., 2008; Graham et al., 2011) which the training should have time to address. This study provides recommendations for LIFT

psychology to implement to help improve the suicide risk training they give to GPs. However, LIFT psychology only provide the suicide risk training on an ad-hoc basis which presents a larger problem as GPs are not being offered regular suicide risk training opportunities, in line with guidelines from the DoH (2007). This is something that should be addressed by GPs surgeries on a local and national level. To address this, the STORM suicide training programme should be given to all GPs, every three years, to ensure that they are receiving quality training that is evidence based. The STORM programme focuses on developing the skills needed to help a person who is at risk of suicide.

### **Service improvement recommendations**

- Clinical governance: to create a robust recording system for monitoring and recording which GPs take part in the training.
- Process: for LIFT psychology to work more closely with practice managers so that they are able to inform them when a GP requires training, whether it be a GP who has recently been recruited or a GP whose training needs to be updated.
- Training content: to incorporate an up to date overview of the evidence base to suicide risk training in their training programme. To inform GPs of the referral pathway for acute management of risk and the criteria for secondary care services.
- Evaluation: to measure the effectiveness of the suicide risk training using the questionnaire designed for this study.

### **Wider implications of research**

This study has highlighted a high proportion of GPs in Swindon who have not received suicide risk training. Such findings can be used as evidence for the need to continue to offer suicide risk training to all GPs. This would also be supported by the DoH (2012) who have highlighted the importance of strengthening the suicide risk training that GPs receive. The wider distribution of the suicide risk training is likely to ensure that a larger number of GPs will have increased clinical skills in assessing suicide risk. This could contribute to helping ensure that patients at risk of suicide receive the most appropriate level of care, proportionate to their level of risk. Ultimately, better management of suicide risk may contribute to a reduction in the number of suicide attempts in Swindon. The findings from this study may also be of interest to researchers who are looking to conduct more rigorous research around prevention and management of suicide risk in GP surgeries. These findings could also have implications for Swindon's Public Health Department as it

highlights that suicide risk training for GPs should be closely monitored and evaluated to help ensure that GPs are equipped to conduct suicide risk assessments adequately.

### **Limitations**

The study could have been improved by having two equal sized groups of GPs who attended training and GPs who did not attend the training. The small sample size ( $n = 7$ ) in the group of GPs who attended the suicide risk training may not be representative of all the GPs in Swindon who attended the training. A larger sample of GPs who completed the suicide risk training would have allowed more accurate, representative conclusions to be drawn about the usefulness of the suicide risk training. However, all 145 GPs in Swindon were contacted about the study with 30 participating and 115 declining to take part.

The study may have also recruited a biased sample of GPs as the GPs who agreed to take part in this study may have been more likely to agree to take part in the suicide risk training. Similarly, GPs who were interested in mental health or service improvement work may have been more likely to fill in the questionnaires. This could have limited the generalizability of the findings to other GPs in Swindon who did not take part in the study.

The questionnaire was not validated as it was designed purely for the purpose of this study. On reflection, the questionnaire could have included more specific questions regarding what changes could be made to training to help adequately address question 3 of the study aims.

The suicide risk training was completed at individual GP surgeries between August 2013 – March 2014 and the evaluation of the training took place between July 2014 and September 2014. The time gap between when the training was delivered and when the training was evaluated may have influenced GPs responses to the evaluation as they were being asked to comment on their experience of training which could have taken place any time from 5-9 months earlier. Therefore it might have been more difficult to recall exactly what the training consisted of and what was learned.

A further limitation of this evaluation is that the questionnaire did not directly assess the impact of the suicide risk training on GPs knowledge. This was because the questions were not specifically related to what the GPs had learned in the training or may have already

known. For example, a GP might have known about the indicators of risk before they completed the training. Therefore when asked if they know about the indicators of risk they were going to say yes but this was not due to learning it in the training. Any future questionnaires could be more specifically related to the GPs knowledge pre and post training. For example before training did you know about the indicators of risk? If no, has the training equipped you with knowledge about the indicators of risk? This type of questioning would help ensure that GPs suicide risk knowledge has come directly from the training.

This study aimed to retrospectively evaluate the usefulness of the suicide risk training. Whilst it was helpful in answering the aims of this study, it only assessed the GPs subjective interpretation of the training, rather than the specific impact of the suicide risk training on the GPs knowledge of suicide risk. Any future evaluation may also benefit from using a pre-training, post-training and a follow up measure to establish the direct impact of the suicide risk training on GPs knowledge. Future research could also explore this in more depth through completing semi-structured interviews with GPs. This could include questions around exploring GPs attitudes to mental health and suicide. Furthermore, it might also be helpful to examine GPs level of knowledge and skills around suicide risk management from the perspective of the patients presenting with a suicide risk.

### **Service response**

A feedback meeting was arranged with Hannah Foster (high intensity CBT practitioner) and Liz Howells (Clinical Psychologist and manager of LIFT psychology in Swindon) to discuss this service improvement report and its recommendations. The report was well received and they were pleased to find out that the training had been evaluated positively by the GPs who had taken part. More specifically they thought the report was well structured and gave a clear rationale for why LIFT psychology offers suicide risk training to GPs.

At the meeting we reviewed the recommendations from the report and their feedback for each one has been summarised below:

1. To create a robust recording system for monitoring and recording which GPs take part in the training.

LIFT psychology currently have a database for recording which GP surgeries accept or decline the training but they are also going to ask GPs to complete a register so they can record which GPs attend their training sessions.

2. To routinely evaluate the suicide risk training using the same questionnaire that was used in this evaluation.

The questionnaire used for this evaluation will be used to monitor the effectiveness of future training that LIFT psychology provide. The questionnaire will be adapted for GPs who attend the training so questions 1-7 will be removed.

3. For LIFT psychology to work more closely with practice managers so they are able to inform LIFT psychology when a GP requires training – whether it be a GP who has recently been recruited or a GP whose training needs to be updated.

LIFT psychology have not received any funding to provide this training. As a result they are unable to offer training each time a new GP has been recruited or if a GPs training needs to be updated. Therefore LIFT psychology were clear that they have to keep this training manageable and within their remit. They will continue to offer the training to GP surgeries when resources permit.

4. To incorporate an up to date overview of the evidence base to suicide risk training in their training programme.

Due to lack of funding LIFT psychology are unable to justify allocating time to implement this change across GP surgeries. In future training sessions LIFT psychology will make reference to the NICE guidelines. GPs will then need to research this information themselves if they are interested.

5. To inform GPs of the referral pathway for acute management of risk and the criteria for secondary care services.

LIFT psychology will not be able to implement this recommendation as it is not their responsibility or within their remit to provide training on the management of complex case presentations. Francis Mayes (Senior Public Health Manager) will feed this request from GPs back into the suicide prevention strategy so that they can think about how this might be addressed.



**From the meeting the following action points were agreed:**

1. For LIFT psychology to complete a register of GPs who attend future suicide risk training sessions.
2. For LIFT psychology to use the questionnaire from this evaluation to evaluate any future suicide risk training.
3. For LIFT psychology to offer suicide risk training to GPs who had requested it through the questionnaires from this project.
4. For Francis Mayes to feed the results of the presentation back to the suicide prevention strategy.

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## **Reassurance seeking in Obsessive-Compulsive Disorder and depression**

Emma Smith

Doctoral Programme in Clinical Psychology, Department of Psychology, University of Bath, Claverton Down, Bath, BA2 7AY, Tel: 01225 385506, Email: [es600@bath.ac.uk](mailto:es600@bath.ac.uk)

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Internal supervisor: Professor Paul Salkovskis

External supervisor: Dr Neil Carrigan

Proposed Journal: *Journal of Behaviour Therapy and Experimental Psychiatry*

(see Appendix F)

This journal was chosen as it is targeted at understanding the mechanisms that cause or perpetuate mental health disorders.

## **Abstract**

*Background and Objectives:* It has been suggested that reassurance seeking may play an important role in the development and maintenance of common mental health problems such as OCD and depression. We first considered the extent of reassurance seeking in depression and OCD relative to a healthy comparison group and secondly tested the hypothesis that reassurance seeking is primarily motivated by threat in those suffering from OCD and by interpersonal concerns in those suffering from depression.

*Methods:* The frequency and intensity of reassurance seeking and the motivation for seeking reassurance was measured using the reassurance seeking questionnaire in 28 people with OCD, 18 people with depression and 29 healthy controls.

*Results:* The OCD group sought reassurance more and at a higher intensity than both the depression group and healthy controls. For the OCD group, reassurance seeking was found to be linked to threat concern motivation. The depression group were not motivated by threat or interpersonal concerns.

*Conclusions:* For people suffering from OCD, reassurance is motivated by threat concern. For the depression group the motivation to seek reassurance is less clear but interpersonal concern may not be a distinct motivational factor.

*Key words:* Reassurance seeking, Obsessive-Compulsive Disorder, depression, reassurance seeking questionnaire, threat motivation, interpersonal motivation.

## Introduction

Reassurance seeking is a common interpersonal reaction to feelings of anxiety and ideas of threat (Kobori & Salkovskis, 2013). When a person feels threatened or anxious they often seek reassurance, from either a loved one, a professional or through internet resources, to help relieve their anxiety. For this reason, many people will have experienced reassurance seeking as a helpful behaviour in their day to day lives (Salkovskis & Kobori, 2015). This explains why it can be viewed as a helpful strategy for friends, family and health care professionals to offer when someone is anxious (Salkovskis & Kobori, 2015). However, over the past two decades there has been research which has examined the role of excessive reassurance-seeking (ERS) in perpetuating emotional distress and interpersonal difficulties (Parrish & Radomsky, 2010). In particular, reassurance seeking has been identified not just as a symptom but also as an important factor in the *maintenance* of disorders such as OCD (Salkovskis, 1989) and health anxiety (Warwick & Salkovskis 1990). However, it has also been suggested that ERS is prominent in depression (Coyne, 1976<sub>a</sub>).

According to Coyne's (1976<sub>a</sub>) interpersonal theory of depression, ERS is involved in the maintenance of the problem and depressed individuals seek reassurance regarding their value to others in an effort to increase relationship security. Reassurance is then scrutinized for its sincerity and consequently more reassurance is sought as the person doubts the reassurance and assumes people have given reassurance out of a sense of pity or because they feel an obligation to (Coyne, 1976<sub>a</sub>). Such behaviour can irritate others which then makes it likely that it will increase social rejection and thus confirm their depressive cognitions around being unlovable and unworthy (Coyne, 1976<sub>a</sub>). According to this theory, reassurance seeking impacts on depression because it elicits rejection from others (Coyne, 1976<sub>a</sub>). Subsequent research is consistent with this by showing that students who were depressed were more likely to seek reassurance and it is the combination of depression and reassurance seeking that leads to rejection from others. Furthermore, a meta-analysis found that higher levels of ERS are associated with a greater number of depressive symptoms (Starr & Davila, 2008) which supports Coyne's (1976<sub>a</sub>) interpersonal theory of depression.

Joiner's et al. (1993) integrated interpersonal theory of depression builds upon Coyne's (1976<sub>a</sub>) work and combines it with Swann's (1987) which suggests that cognitive and affective reactions to feedback are incongruent in people with negative self – views

(Swann, Griffin, Predmore, & Gaines, 1987). Joiner's et al. (1993) research measured levels of depression, reassurance seeking and interpersonal factors using questionnaire measures at three points in time. The participants recruited were depressed students, non-depressed students and their room-mates. Overall, this research found that depressed individuals who sought both reassurance and negative feedback were more likely to be negatively evaluated by their room-mates than people who were depressed and did not seek reassurance or negative feedback (Joiner et al., 1993). Joiner et al. (1993) concluded that people with depression seek reassurance to console emotion and consequently when reassurance is sought people are affectively satisfied (Joiner et al., 1993). However this is only temporary as there is a discrepancy between negative self-concept, and the reassurance, once it has been cognitively processed (Joiner et al., 1993). Therefore people with depression seek negative feedback from others in order to confirm their depressive beliefs about their self-worth. According to Joiner et al. (1993) it is an interaction of depression, reassurance seeking and negative feedback seeking which cause people with depression to be rejected by others.

In Obsessive-Compulsive Disorder (OCD) reassurance seeking is regarded as different in both form and function. Salkovskis and colleagues argue that reassurance seeking is best conceptualised as a "super-safety seeking behaviour" (Kobori, Salkovskis, Read, Lounes, & Wong, 2012) which is motivated by obsessional beliefs and interpretations (Salkovskis, 1985; 1999). The intention behind reassurance seeking is for the person with OCD to ensure that they have done their best to prevent harm and to disperse responsibility for it to another person (Rachman, 2002). Qualitative work suggests an important motivator for reassurance seeking in OCD is to reduce uncertainty (Kobori et al., 2012). However, the relief of anxiety, after reassurance seeking, is temporary (Salkovskis, 1999; Rachman, 2002; Salkovskis & Kobori, 2015). Consequently, based on the cognitive model of OCD, reassurance seeking is targeted in treatment as it prevents the disconfirmation of catastrophic beliefs concerning harm and responsibility for it (Clark, 2004; Salkovskis & Warwick, 1985). Due to the interpersonal nature of reassurance seeking, people with OCD cannot always rely on getting consistency with this behaviour in the same way as they can with other safety seeking behaviours, such as checking (Salkovskis & Kobori, 2015). When a consistent response is received, it tends to be at a detriment to the other person's participation as it can be highly aversive for them (Salkovskis & Kobori, 2015).



Previous research has examined the frequency, process and sources of reassurance seeking in OCD compared with panic disorder and community controls (Kobori & Salkovskis, 2013). This research showed that individuals with OCD were more likely to employ self – reassurance and to seek reassurance more *intensely* and *carefully* (Kobori & Salkovskis, 2013). Research into reassurance seeking has also been investigated in qualitative work which has assessed the factors involved in the onset, maintenance and termination of ERS with non-depressed OCD respondents and clinically depressed individuals (Parrish & Radomsky, 2010). This research showed that individuals with OCD tend to seek reassurance about general threats, whereas individuals with depression tend to seek reassurance about social threats (Parrish & Radomsky, 2010). However this work was qualitative, consisted of a small sample size and only gave a preliminary indication of the motivation for seeking reassurance.

The present research will aim to expand upon this knowledge and quantify the extent of ERS in OCD and depression and differences in terms of motivating beliefs in reassurance seeking in OCD and depression. Thus, although the topography of reassurance seeking in OCD and depression may be similar, the function and effect appears different and are informed here by different theoretical positions.

For the person with OCD, there is a perception of threat and the person seeks reassurance in an attempt to be certain that harm will not happen and that they are not to blame. Therefore they are seeking complete certainty that the consequence will not happen. For example, in OCD: “I know it’s not likely, but what if I my husband does not love me? I need to be certain!” leading to the reassurance seeking question “Do you love me? Really?” In contrast, a person with depression will hold strong, near certain negative beliefs and will seek reassurance in the remote hope that they can move to a position of greater uncertainty. For example, “I am almost certain that my husband does not love me, but what if there is a chance I am wrong?”.

The purpose of the present study is to examine the hypothesis that reassurance seeking is frequent in both OCD and depression but is primarily motivated by threat concerns in those suffering from OCD and interpersonal concerns in people suffering from depression.

## **1. Hypothesis**

1. The OCD group will score higher on a measure of threat as a motivator for reassurance in comparison to the depression group and control group who will not differ.
2. The depression group will score higher on a measure of interpersonal concern motivating reassurance in relative to the OCD and control group.
3. Both OCD and depression groups will seek more reassurance than the control group.

## **2. Method**

### *2.1 Design*

In a cross-sectional design, participants experiencing OCD or depression were asked to fill in four questionnaire measures on anxiety, depression, OCD and reassurance seeking. A benchmark comparison group of non-clinical community controls suffering from neither also completed the measures. As anticipated there was some comorbidity allowing a fourth group (those with a main diagnosis of depression with comorbid OCD) to be incorporated and compared with the main criterion groups for secondary analyses (i.e., exploratory factor analysis, stepwise regression).

### *2.2 Measures*

Patient Health Questionnaire- 9 item version (PHQ-9) (Kroenke, Spitzer, & Williams, 2001). This brief diagnostic measure of depression severity is reported to be valid with an excellent internal reliability (Cronbach  $\alpha = 0.89$ ; Kroenke et al., 2001). The 9 items are rated on a scale of 0 (not bothered me at all) – 3 (bothered me nearly every day) for how things have been in the past two weeks.

Generalised Anxiety Disorder- 7 item version (GAD-7) (Spitzer, Kroenke, Williams, & Lowe, 2006) is a self-report measure which screens and assesses the severity of GAD and has been identified as having good test-retest reliability (intraclass correlation = 0.83)

(Spitzer et al., 2006). The 7 items are rated on a scale of 0 (not bothered me at all) – 3 (bothered me nearly every day) for how things have been in the past two weeks.

Obsessive Compulsive Inventory (OCI) (Foa, Kozak, Salkovskis, Coles, & Amir, 1998). A 42- item self-report scale which measures the degree of distress experienced as a result of OCD symptoms. The OCI demonstrates satisfactory reliability and validity with high alpha coefficients (.86 - .95) for the full scale (Foa et al., 1998). There are seven subscales; washing, checking, doubting, ordering, obsessing, hoarding and mental neutralising. Each item is rated on a scale from 0 (has not distressed me at all) – 4 (has distressed me extremely).

The Reassurance Seeking Questionnaire (ReSQ) (Halldorsson, 2015). This questionnaire consisted of eight subscales; source of reassurance seeking (source), motivational factors<sup>3</sup> (OCD threat), how reassurance is sought (how), process of reassurance seeking (difficulties), interpersonal care, post reassurance affect (post), negative interpersonal effect (negative impact on others), insight about negative aspects of reassurance seeking (insight). Ten questions were added to this questionnaire to ensure that the motivating beliefs, that influenced reassurance seeking in the depression sample, were examined. The selection of these additional questions (see Appendix G) was informed by the Interpersonal Model of Depression (Coyne, 1976) which suggests that people with depression seek reassurance regarding their value to others and to help increase relationship security. These items were derived from our understanding of this model and sought to reflect it as closely as possible. Alongside this the main researcher and supervisor reviewed the 4 item reassurance seeking subscale from the Depression Interpersonal Relationship Inventory (DIRI) which was developed by Metalsky, Joiner and Potthoff, 1995. The reassurance seeking questions in this subscale related to whether others truly care (E.g. do you frequently seek reassurance from the people you feel close to as to whether they really care about you?). Based on this information, the main researcher used this information to come up with 10 additional questions that addressed these areas. Two additional subscales were then derived: interpersonal reassurance (depression interpersonal - as a scale to test the interpersonal model of depression) and perceived interpretations of reassurance as an

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<sup>3</sup> Question 19 (when I seek reassurance it brings me closer to the other person) and 34 (I feel that nothing can substitute for reassurance) were removed from this subscale and were not included in the analysis as they were not related to OCD threat.

additional interpersonal variable. The validation of these scales was based on an exploratory factor analysis which is reported at the end of the method section. The depression interpersonal subscale and OCD threat subscale were then used in the main analysis to evaluate the main hypothesis. This questionnaire was piloted with four healthy controls to ensure that it was comprehensible. The feedback stated that the questionnaire took 15 minutes to complete and the instructions and questions were clear and easy to follow.

The Mini International Neuropsychiatric Interview (M.I.N.I) (Sheehan & Lecrubier, 2010) is a short, structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders. The M.I.N.I is fully validated and recognised as a time efficient alternative to the Structured Clinical Interview for DSM diagnoses (SCID-P) (Sheehan et al., 1997).

### *2.3 Participants*

According to G Power 3.1.5, to achieve power of 0.8 with alpha set at 0.05 and a large effect size of 0.8, the calculated sample size required for this study was 66 (twenty two per group). Recruitment was planned to continue until all groups met this target at least. Participants were recruited for three groups based on their main clinical diagnosis confirmed by the OCD or depression section of the MINI. To take part in the research, participants had to be at least eighteen years old, have a diagnosis of OCD or depression and be able to read and write in English. Potential participants were excluded from taking part in the study if they had a history of psychosis or if they had a current alcohol or substance misuse problem. Based on this twenty eight individuals met the criteria for primary OCD (OCD group), eighteen individuals met the criteria for primary depression (depression group) and eleven individuals met the criteria for primary depression and also presented with OCD. Twenty nine non-clinical community controls were also recruited to a healthy control (benchmarking) group. Clinical participants were identified through NHS primary and secondary mental health services and an OCD charity. The demographic details of the participants are presented in Table 2.

### *2.4 Procedure*

This study received ethical approval from the National Research Ethics Service (NRES) Committee North West - Lancaster (see Appendix H). Potential participants were identified and approached by either their clinician or Everyone Included. Everyone Included is a service within Avon and Wiltshire Mental Health Partnership (AWP) which informs service users of research opportunities. An AWP Research and Development (R&D) staff member from Everyone Included conducted a search of up-to-date electronic records based on the inclusion/exclusion criteria. The search excluded people who did not want to receive information through Everyone Included. Letters were then posted to potential participants inviting them to take part in the research (see Appendix I).

If after receiving a letter or speaking to a clinician someone was interested in taking part in the research, they were given an information sheet (see Appendix J) and asked for permission to pass on their contact details. If they consented to this then their details were given to the main investigator who contacted the participants on the telephone to complete either the OCD or depression section of the MINI. If they met the criteria for taking part in the research then a pack of four questionnaires and a consent form (see Appendix K) was sent out in the post. Participants then filled in the questionnaires and consent form and returned them in a freepost envelope provided by the researcher. Once the completed questionnaires were returned to the researcher, the participant was sent a voucher to thank them for participating in the study.

For depressed participants who scored above 40 on the OCI the clinical data was discussed with the lead investigators supervisor, without knowledge of the results on any dependent variables. Thus a blinded decision was made regarding group inclusion. Typically where the supervisor was satisfied that high self-report OCI scores were in fact reflecting symptoms of depression (i.e. such as rumination) participants were retained in the depression group. This process involved fourteen people, of which one was excluded from the analysis, two were retained in the depression group and eleven people were placed in a fourth group (depression and OCD).

### *2.5 Exploratory Factor Analysis: interpersonal reassurance components*

A factor analysis, using Varimax rotation, was conducted to determine the constructs for the ten questions that were added to the reassurance seeking questionnaire.

The model that best fit the data was based on two factors:

1. Reassurance to make sure I am loved (interpersonal motivation)
2. Perceived interpretation of reassurance

For each item factor loading, means and standard deviations are presented in table 1. Each questionnaire item could be scored 0 ('never') to 5 ('always'). Factor loadings below 0.5 were suppressed. Items with multiple loadings (two items) were either allocated to the factor with the highest loading or to the factor that made more conceptual sense (Pett, Lackey, & Sullivan, 2003).

## 2.6 Internal consistency

The subscales' internal consistency was then calculated using Cronbach's alpha. The internal consistency (Cronbach Alpha) for the ten questions that were added to the Reassurance Seeking questionnaire was .944. The internal consistency for subscale one was .949 and for subscale two was .857. This suggests excellent internal consistency in the questions added and in the two subsequent subscales.

Table 1. Factor loadings, means, standard deviations (SD) and item total correlations

Factor 1 – Reassurance to make sure I am loved	Factor loadings:	Mean	SD	Overall item total correlations	Item total correlations for each scale
Item 17: I seek reassurance a lot from people close to me because I do not believe my relationship (with them) is very secure	.782	1.44	1.61	.804	.790
Item 28: I seek reassurance to prevent myself feeling unloved	.872	1.70	1.79	.820	.852
Item 32: I seek reassurance mainly because I hope that I can discover whether people important to me truly care about me	.841	1.36	1.61	.840	.852
Item 36: I seek reassurance to try to improve how secure my relationship is	.865	1.28	1.66	.797	.867

Item 41: I seek reassurance as a way of increasing how secure my relationship is	.808	1.38	1.70	.855	.857
Item 44: I seek reassurance about whether those I care for value me in the way I want them to	.885	1.60	1.70	.820	.846
Factor 2 –Perceived interpretation of reassurance					
Item 5: If I notice the person getting irritated when I am seeking reassurance I seek it more	.871	1.13	1.54	.476	.564
Item 10: If people do not give me reassurance it is because they do not care enough about me	.790	1.34	1.63	.725	.793
Item 15: I seek reassurance to try and stop people rejecting me	.638	1.55	1.77	.735	.792
Item 38: I seek reassurance even though doing this might damage how much they care about me	.551	1.29	1.56	.828	.731

### 3. Treatment of Data

1. The data was examined for missing values. When there was one item missing per subscale, data were imputed using the Mode (Field, 2013).
2. The participant's demographic status was examined to see whether the groups were comparable. One-way ANOVAs were conducted for categorical data and Chi-square tests and Fisher Exact tests were performed for non-categorical data as appropriate.
3. The participants' measure of general psychopathology were examined as a way of describing and defining the groups. A series of one-way ANOVAs were conducted where group (healthy controls vs. OCD/depression, depression vs. OCD) served as the between participants factor and participants scores on each questionnaire served as the outcome variable. For significant main effects, LSD post hoc tests were performed. If there was a violation to the assumption of equal variance, i.e. Levene's test was significant, adjusted F statistics were applied using Dunnett  $t^3$ .

### 4. Data analytic strategy

All data were managed and analysed using IBM SPSS (2013). The data analytic strategy was as follows:

1. A mixed model ANOVA was conducted with group as the between subjects factor and subscales as the within subjects factor.
2. Where indicated by a significant interaction, one-way ANOVAs (simple main effects) with post-hoc tests (LSD or, where homogeneity of variance problems were detected by Levene's test, the Dunnett  $t^3$ ) were performed.
3. Paired t-tests were conducted to explore within group differences between scores on the threat and interpersonal motivation scales.
4. A stepwise multiple regression analysis was carried out as a secondary exploratory analysis to determine the association between the independent variables (i.e., threat subscale, depression subscale, PHQ-9 and GAD-7) and the dependent variables (i.e. frequency of reassurance seeking, intensity of reassurance seeking). Stepwise multiple regression was used, with the four variables allowed to enter freely.

## 5. Results

### 5.1 Demographic Status

The demographic status for each group is presented in Table 2. A one-way ANOVA was conducted for age and revealed a significant main effect of group ( $F_{(2, 74)} = 5.83, p < 0.05$ ). The Levene test indicated homogeneity of variance. Multiple comparison using LSD showed that the healthy control group and OCD group were significantly younger than the depressed group (all  $p$ 's  $< 0.005$ ). The healthy control group and OCD group were not significantly different. A correlation analysis was conducted to determine whether age was related to the two key dependent variables and it was not for age and OCD threat motivation ( $R_{86} = -0.09, p > 0.4$ ) or age and interpersonal motivation ( $R_{86} = 0.03, p > 0.8$ ), which means that this group difference is unlikely to confound any effects. The groups did not differ in terms of gender ( $X^2(3) = 1.203, p = .752$ ), qualifications ( $P = 0.64$ , Fisher's exact test) and relationship status ( $P = 0.40$ , Fisher's exact test). No statistics were conducted for ethnicity as the majority of participants were Caucasian (93%).

Table 2. Demographic status of participants.



		OCD (n=28)	Depression (n=18)	Healthy controls (n=29)	Depression and OCD (n=11)
Gender	Female; Male	17;11	12;6	15;14	7;4
Age	M (SD)	37 (10.9)	47 (15.9)	32 (15.5)	41 (12.7)
Ethnicity	Caucasian	89% (25)	94% (17)	100% (29)	82% (9)
	Asian	4% (1)	0% (0)	0% (0)	0% (0)
	Other	7% (2)	6% (1)	0% (0)	18% (2)
Highest educational qualification	Secondary	18% (5)	22% (4)	31% (9)	36% (4)
	Degree	50% (14)	61% (11)	55% (16)	46% (5)
	Post graduate	32% (9)	17% (3)	14% (4)	18% (2)
Marital status	Single	39% (11)	17% (3)	45% (13)	36% (4)
	Married	57% (16)	55% (16)	55% (16)	18% (2)
	Separated	4% (1)	28% (5)	0% (0)	46% (5)

## 5.2 General measures of psychopathology

### 5.2.1 PHQ-9 and GAD-7

A one-way ANOVA revealed a significant main effect of group on the PHQ-9 and GAD-7 (see Table 3 for means and  $F$  values). Multiple comparisons (using either LSD or Dunnett  $t^3$ ) showed that the OCD and depression group scored significantly higher on the PHQ-9 and GAD-7 than healthy controls ( $p < 0.05$ ). There was no significant difference between the depression group and OCD group on these measures.

### 5.2.2 Obsessive Compulsive Inventory

A one-way ANOVA revealed a main effect of group on all OCI subscales (see Table 3). The OCD group scored significantly higher on the OCI than the other two groups ( $p < 0.05$ ). When considering the OCI subscales, multiple comparisons showed there was no significant difference between the OCD and depression group on the hoarding measure ( $p = .341$ ). As expected the OCD group scored significantly higher on all other subscales

compared to the other two groups ( $p < 0.05$ ). The depression group scored significantly higher on the OCI total and obsessions subscale than the healthy control group ( $p < 0.05$ ).

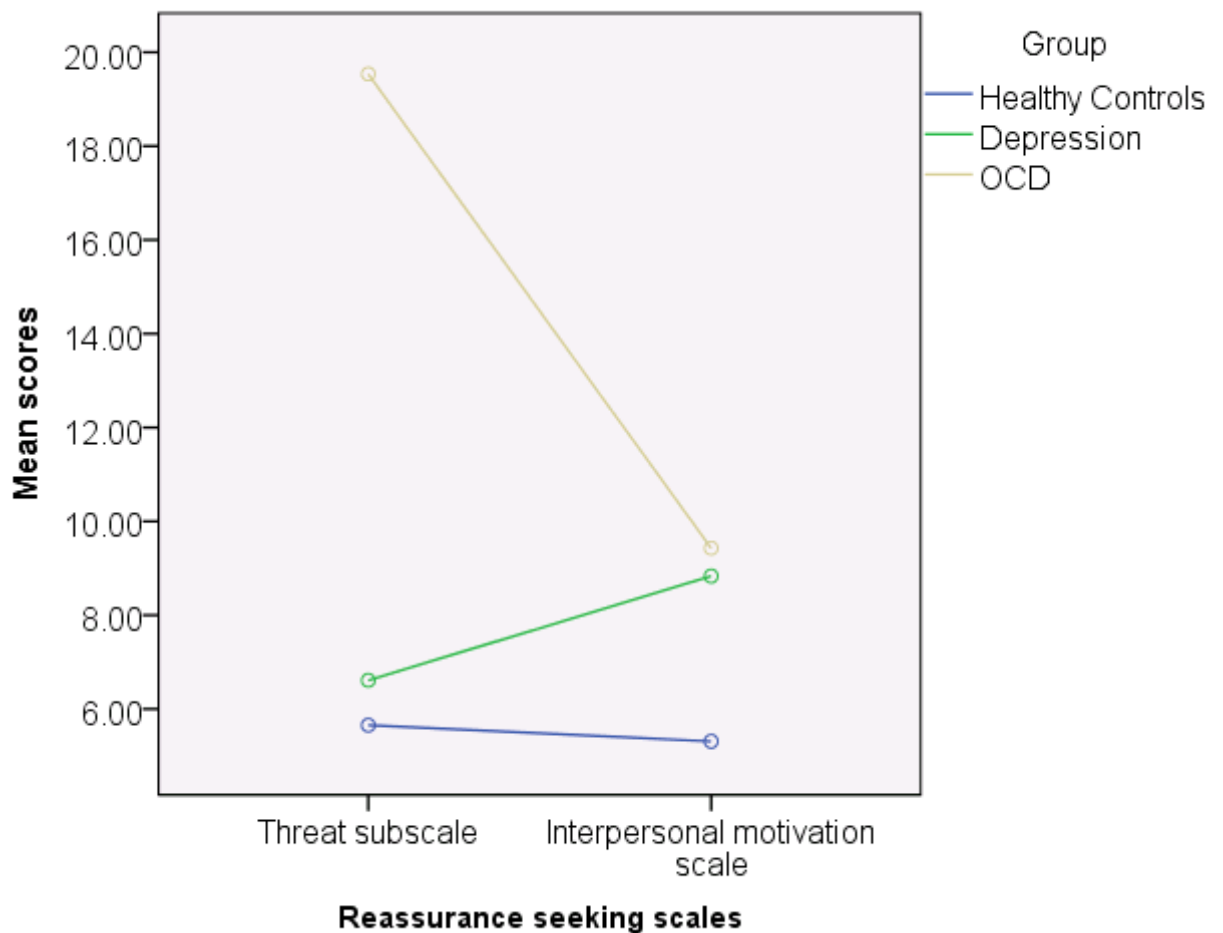
Table 3. Presenting mean (standard deviation) for general measures of psychopathology across groups.

Variable	OCD (n=28)	Depression (n=18)	Healthy controls (n=29)	<i>F</i> (2,74)
	Mean (SD)	Mean (SD)	Mean (SD)	
PHQ-9	13.86 <sup>a</sup> (6.14)	16.22 <sup>a</sup> (6.60)	3.38 <sup>b</sup> (2.54)	44.071
GAD-7	13.43 <sup>a</sup> (4.63)	11.50 <sup>a</sup> (4.94)	3.10 <sup>b</sup> (2.98)	48.401
OCI (total)	68.68 <sup>a</sup> (28.04)	26.33 <sup>b</sup> (16.73)	11.76 <sup>c</sup> (9.42)	61.445
Wash	9.79 <sup>a</sup> (10.66)	1.89 <sup>b</sup> (3.36)	1.52 <sup>b</sup> (2.37)	12.214
Doubt	6.32 <sup>a</sup> (3.41)	1.89 <sup>b</sup> (1.91)	1.14 <sup>b</sup> (1.36)	11.996
Order	5.93 <sup>a</sup> (4.60)	2.44 <sup>b</sup> (2.64)	1.69 <sup>b</sup> (2.32)	72.003
Obsession	19.07 <sup>a</sup> (5.57)	11.50 <sup>b</sup> (7.46)	2.45 <sup>c</sup> (2.60)	3.672
Hoarding	2.75 <sup>a</sup> (2.82)	2.11 <sup>ab</sup> (2.42)	1.17 <sup>b</sup> (1.14)	35.570
Neutralizing	10.61 <sup>a</sup> (6.64)	2.72 <sup>b</sup> (2.35)	1.45 <sup>b</sup> (1.57)	43.628
Check	14.21 <sup>a</sup> (7.22)	3.78 <sup>b</sup> (3.95)	2.34 <sup>b</sup> (2.68)	35.960

Note: Group Means with different superscripts differed significantly at the 0.05 level. The same superscript represents no significant difference between groups. Groups with two superscripts show that there is no significant difference between that group mean and the two other group means. No superscripts represents no significant differences between groups.

### 5.3 Analysis of beliefs motivating reassurance seeking

Beliefs motivating reassurance seeking was the key analysis conducted to test the hypothesis regarding the different motivations for reassurance seeking in depression and OCD. A mixed model ANOVA was conducted with the three groups (depression group, OCD group and healthy control group) as the between-subjects factor and the threat subscale and interpersonal motivation subscale as the within-subjects factor. Significant main effects for subscale type ( $F_{(1, 72)} = 9.3, p < 0.005$ ) and group ( $F_{(1, 72)} = 15.85, p < 0.001$ ) were found. These main effects were modified by a significant interaction between subscales and group ( $F_{(2, 72)} = 18.12, p < 0.001$ ). This interaction is shown in figure 1.



**Figure 1.** The interaction between group allocation and the two reassurance seeking subscales.

The interaction was thus tested using a simple main effects ANOVA which revealed a significant main effect for group on the threat subscale ( $F_{(2, 74)} = 41.8, p < 0.001$ ). Multiple comparisons using LSD revealed that the OCD group scored significantly higher on the threat subscale than both the depressed group and healthy control group ( $p < 0.005$ ). The depressed group were not significantly different to the healthy control group ( $p = 0.609$ ). The main effect for group on the interpersonal motivation subscale was not significant ( $F_{(2, 74)} = 2.02, p = .140$ ). Further analysis using paired sample t-tests allowed comparison of each group in terms of the relative levels of threat and interpersonal motivation scales. Within the OCD group threat motivation scores ( $M = 19.54, SD = 7.28$ ) were significantly higher than interpersonal motivation scores ( $M = 9.42, SD = 9.93$ ) ( $t_{(27)} = 5.02, p < 0.005$ ). There was no significant difference on scores of threat and interpersonal motivation scales

for the depression group ( $t_{(17)} = -2.099, p = 0.051$ ) or healthy control group ( $t_{(28)} = .356, p = .725$ ).

#### *5.4 Extent, reactions to and impact of reassurance seeking*

The full range of reassurance seeking was compared across groups. As indicated in table 4, a one-way ANOVA showed that apart from the interpersonal motivation subscale ( $p = 2.021$ ), the RSQ total and all other RSQ subscales showed significant main effect of group ( $p < 0.005$ ). Multiple comparisons showed that the OCD group scored significantly higher on the RSQ total than the other two groups ( $p < 0.05$ ). There was no significant difference between the depression group and healthy control group on the RSQ total ( $p = 0.089$ ).

All groups scored significantly differently from each other on the post affect scale ( $p < 0.05$ ). This shows that the OCD group are most sensitive to feelings of guilt, followed by the depression group who are significantly different from the healthy control group. There was no significant difference between the OCD and depression group on the interpersonal care subscale ( $p = 0.076$ ), but both groups were significantly different to the healthy control group ( $p < 0.05$ ). This highlights that the OCD group were most sensitive to the impact of reassurance seeking on other people, followed by the depression group who were significantly different to the healthy control group. The OCD group scored significantly higher on all other subscales compared to the other two groups ( $p < 0.05$ ). This shows that OCD group are seeking reassurance at a higher frequency and intensity than the other two groups.

The depression group scored significantly higher than the healthy control group on the perceived negative reactions subscale ( $p < 0.05$ ). There was no significant difference between the depression group and the healthy control group on the remaining RSQ subscales. Overall, this shows that the depression group are more concerned than the healthy control group about the impact of reassurance seeking on others, the post affect around reassurance seeking and around perceived negative reactions associated with reassurance seeking.

Table 4. Presenting means (standard deviations) for the measure of reassurance seeking across groups.

Variable	OCD (n=28)	Depression (n=18)	Healthy (n=29)	<i>F</i> (2,74)
	Mean (SD)	Mean (SD)	Mean (SD)	
RSQ (total)	123.89 <sup>a</sup> (42.09)	62.28 <sup>b</sup> (45.92)	42.38 <sup>b</sup> (28.55)	33.872
Source (frequency)	14.0 <sup>a</sup> (5.04)	7.67 <sup>b</sup> (5.86)	7.21 <sup>b</sup> (4.48)	15.137
How (intensity)	23.00 <sup>a</sup> (8.12)	7.61 <sup>b</sup> (7.93)	7.17 <sup>b</sup> (5.13)	43.189
Difficulties (resistance)	12.61 <sup>a</sup> (4.92)	4.33 <sup>b</sup> (4.93)	2.31 <sup>b</sup> (2.44)	47.705
Interpersonal care (others)	11.57 <sup>a</sup> (3.79)	9.28 <sup>a</sup> (5.17)	5.34 <sup>b</sup> (3.97)	15.815
Post (-ve affect in self)	5.39 <sup>a</sup> (3.36)	3.33 <sup>b</sup> (2.59)	1.10 <sup>c</sup> (1.63)	19.140
Negative impact on others	10.21 <sup>a</sup> (4.90)	4.56 <sup>b</sup> (4.00)	3.14 <sup>b</sup> (3.08)	23.401
Insight	5.57 <sup>a</sup> (3.49)	3.41 <sup>ab</sup> (2.96)	1.72 <sup>b</sup> (1.87)	13.241
Perceived interpretation	7.25 <sup>a</sup> (5.69)	4.89 <sup>a</sup> (4.65)	1.38 <sup>b</sup> (1.70)	13.517
Depression interpersonal	9.43 (9.93)	8.83 (7.69)	5.31 (6.50)	2.021
OCD threat	19.54 <sup>a</sup> (7.28)	6.61 <sup>b</sup> (7.21)	5.66 <sup>b</sup> (4.03)	41.785

Note: Group Means with different superscripts differed significantly at the 0.05 level. The same superscript represents no significant difference between groups. Groups with two superscripts show that there is no significant difference between that group mean and the two other group means. No superscripts represents no significant differences between groups.

### 5.5 Stepwise multiple regression

Two stepwise multiple regressions examined the association between threat motivation, interpersonal motivation, depression (PHQ-9) and anxiety (GAD-7) with frequency and intensity of reassurance seeking. When allowed to enter freely, threat motivation was associated with the frequency of reassurance seeking, this being the only variable which entered ( $F_{(1, 84)} = 113.859, p < .05, R^2 = .575, R^2\text{Adjusted} = .570$ ). Threat motivation was also the only variable freely entering the regression with intensity of reassurance seeking as dependent variable ( $F_{(1, 84)} = 396.012, p < .05, R^2 = .815, R^2\text{Adjusted} = .812$ ). Depression (PHQ-9), anxiety (GAD-7) and interpersonal motivation were not associated with the frequency or intensity of reassurance seeking in either regression.

## 6. Discussion

This study was designed to examine the extent of and motivation for reassurance seeking across depression and OCD based on the contrasting accounts of the interpersonal theory of depression and the responsibility for threat theory of OCD. In particular it examined the

hypothesis that reassurance seeking is primarily motivated by threat in those suffering from OCD and interpersonal concerns in people suffering from depression.

Results indicate that people with OCD sought reassurance at a higher frequency and intensity than people with depression and the healthy control group. Interestingly, whilst the depression group did not seek as much reassurance as the OCD group, both groups reported sensitivity to the impact of reassurance on other people, to the personal perceived negative interpretations around reassurance seeking and to feelings of guilt after seeking reassurance, more than the healthy control group. For people with OCD the main motivation for seeking reassurance was threat. Threat motivation was found to influence the frequency and intensity of reassurance seeking in the OCD sample. This was, however, not the case for the depression group and healthy control group. Depressed participants seem not to be strongly motivated by interpersonal concerns to seek reassurance and were similar in this respect to the OCD group.

Overall the results are consistent with the cognitive-behavioural theory of OCD and reassurance seeking (Salkovskis, 1989). They are less consistent with the interpersonal theory of depression (Coyne, 1976<sub>a</sub>) as they suggest that reassurance is not particularly elevated in people with depression and the motivation to seek reassurance is not particularly about interpersonal concerns.

Previous research has focussed on reassurance seeking in anxiety related problems, particularly OCD (Salkovskis, 1989) and health anxiety (Warwick & Salkovskis 1990). In depression the focus has been on the role of reassurance seeking in the onset and maintenance of depression (Joiner et al., 1993; Swann et al., 1987), rather than looking specifically at the factors that motivate reassurance seeking. One exception to this is the qualitative study by Parrish and Radomsky (2010) which explored reassurance seeking in non-depressed OCD individuals, clinically depressed individuals without OCD and a healthy control group using a qualitative design. There is no previous research which has quantitatively compared the differences in motivation for seeking reassurance in people with OCD and people with depression.

The findings from this research are consistent with the work of Salkovskis (1989), Salkovskis and Kobori (2015), Parrish and Radomsky (2010), Kobori et al. (2012) and

Halldorsson (2015) which shows that reassurance seeking is common and may be a key factor in the maintenance of OCD. It is also in line with the research findings of Kobori and Salkovskis (2013) which found that people with OCD seek reassurance more intensely than people with panic and healthy controls. Other research has found that people with OCD seek reassurance about general threats and people with depression seek reassurance about social threats (Parrish & Radomsky, 2010). Whilst this study also found that people with OCD were motivated to seek reassurance because of threat concerns, social threat was not found to motivate reassurance seeking for the depression group. It might be that the effect of reassurance seeking in transferring responsibility onto another person (i.e. as a super-safety seeking behaviour) may also motivate reassurance seeking. This factor, which is probably unique to OCD, may explain why OCD participants are seeking reassurance more frequently and intensely than those who were depressed.

Coyne (1976<sub>a</sub>) proposed that depressed individuals are particularly likely to seek reassurance regarding their value to others and do so because they seek relationship security. This position is supported by a review of interpersonal processes in depression (Hames, Hagner, & Joiner; 2013) which demonstrated that ERS is a behavioural characteristic of adults with depression. In the present study the depression group did not seek reassurance more than the healthy control group and interpersonal reasons were not found to motivate reassurance seeking. This finding is inconsistent with previous work which suggests that people with depression report seeking reassurance about their own worth and around whether others truly care about them (Coyne's, 1976). Furthermore, people with depression were not found to seek reassurance more frequently or intensely when compared with the OCD and healthy control group. This finding is inconsistent with research which suggests that reassurance seeking is excessively and persistently sought by people with depression about whether they are loveable and worthy (Joiner, Alfano, & Metalsky, 1992; Joiner & Metalsky, 1995). This evidence has come from non-clinical (college-student) samples, whilst the theory is grounded in clinical observation. In relation to the results from this study, it is possible that whilst depressed patients are not seeking more reassurance than healthy controls, they are more concerned about its interpersonal effects. Therefore, it might be that depressed patients are sensitive to the interpersonal effects of depression. This could mean that depressed patients are more interpersonally sensitive regarding any interactions where they are asking others to meet their needs; that is, a generalised interpersonal sensitivity. This supports research which found that people

with depression have high levels of interpersonal sensitivity (Boyce & Parker, 1989; Wilhelm, Boyce, & Brownhill, 2004).

This study adds to the literature on reassurance seeking by confirming that people suffering from OCD seek reassurance more frequently and intensely and that reassurance seeking is motivated by threat concerns for the client group. Given the interpersonal theory of depression and the prevalence of comorbid depression in OCD, we consider that it is now possible to rule depression out as a possible explanation of ERS in OCD.

### *6.1 Limitations*

The depression group fell slightly short of the numbers required by the power analysis, which might have impacted on the overall results. Whilst a fourth group (depression with OCD comorbidity) was generated, the sample size was too small to include in the detailed analyses. Despite this, the overall sample size recruited ( $n = 75$ ) from the three groups was large enough to complete a meaningful quantitative analysis. The depression group were all recruited from mental health services but the OCD sample were from a charity which might have impacted on the results. However, while the participants in the OCD group were recruited from an OCD charity, and therefore a definitive diagnosis of OCD could not be confirmed, their scores on the OCI and RSQ were in line with those generally seen under statutory mental health services.

Additional questions were added to the RSQ for the purpose of this study. The additional questions that were added to the reassurance seeking questionnaire were only piloted in four healthy controls and there was no input or consultation with service users or depression experts about the suitability of the questions. Whilst these questions were used for the first time in this study, they showed high internal consistency and the factors that came out of the exploratory factor analysis mapped onto the Coyne's (1976) interpersonal theory of depression which was used to generate them.

A further limitation is that the OCD group and depression group had similar levels of depression that was significantly different from the health control group. Depression was not screened for in the OCD group when assessing suitability to take part in the study. Therefore it is possible that no significant difference was found between the OCD group



and depression group, on the depression related reassurance seeking subscale, because both groups were equally depressed.

## *6.2 Clinical and research implications*

This research could be used to support the importance of targeting threat and responsibility driven reassurance seeking in the treatment of those suffering from OCD. The findings from this research highlight that for people suffering from depression, it would be more important to address how they respond to the affect associated with reassurance seeking and the negative interpersonal consequences of seeking reassurance. Due to the cross-sectional nature of this study future research should use an experimental design in which variables can be manipulated to explore the different motivational factors that influence reassurance seeking in people with OCD, depression and anxiety. Further research could also use an experimental design to explore differences in reassurance seeking amongst people with low, moderate and severe depression. It might be that the stage of depression influences how much reassurance is sought. For example people with low to moderate levels of depression may seek more reassurance than people with severe depression as the latter group are less likely to interact with people and when they do, they might be highly sensitive to interpersonal concerns.

Overall, the present study indicates that reassurance seeking in OCD is not determined by depression. Surprisingly, there was little evidence suggesting ERS in depression, although there was evidence of interpersonal concern about its occurrence. However, this was present at very similar levels in the OCD group, calling into question whether reassurance is a key factor in the maintenance of depression.

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## **Executive summary**

Reassurance seeking is an interpersonal behaviour that has been found to be an important factor in the maintenance of mental health difficulties, including Obsessive-Compulsive Disorder (OCD) and depression. For this reason reassurance seeking is often targeted in treatment because it can perpetuate emotional distress and interpersonal difficulties.

The cognitive model of OCD states that a person reassurance seeks to ensure they have done their best to prevent harm and as a way of dispersing responsibility onto another person. Reassurance seeking has therefore been found to be unhelpful as it prevents the disconfirmation of catastrophic beliefs regarding harm and responsibility for it.

According to the interpersonal theory of depression, individuals with depression seek reassurance about their values to others and to increase relationship security. However, due to beliefs around low self-worth and being unlovable, the reassurance is often scrutinized for its sincerity and consequently more reassurance is sought. Eventually, due to the interpersonal nature of reassurance seeking, it can have the opposite intended effect and increase rejection from others.

The purpose of this study was to examine the beliefs that may motivate reassurance seeking in people with either OCD or depression. In total 28 people with OCD, 18 people with depression and 29 people healthy controls took part in the research. All participants completed the GAD-7, PHQ-9, OCI and reassurance seeking questionnaire. Ten questions were added to the reassurance seeking questionnaire to help capture interpersonal concern.

Overall, the OCD group sought reassurance more frequently and intensely than the depression group. The OCD group were most sensitive to the impact that reassurance had on other people and the perceived negative reactions associated with reassurance seeking, followed closely by the depression group, who were more sensitive than the healthy control group.

In terms of motivation to seek reassurance, the OCD group were found to be motivated by threat concerns. The depression group were not motivated by threat or interpersonal concerns. Interestingly, whilst both groups were sensitive to the impact of reassurance seeking on other people and to negative reactions from reassurance seeking, it might be

that the threat concern for the OCD group is so great that they continue to seek reassurance anyway. What might be unique for the OCD group is the transfer of responsibility onto another person that takes place when seeking reassurance. For the depression group, the fear of social rejection and cognitions around low self-worth might prevent them from seeking reassurance as much as they would like. Given the prevalence of comorbid depression in OCD, depression can be ruled out as possible explanation of excessive reassurance seeking.

The study was limited by the cross-sectional nature of the design. However, the findings are interesting as they show that reassurance seeking is motivated by threat concern for the OCD group. The lack of interpersonal or threat motivation in the depression group could be explored further to understand what is happening for people with depression. Therefore this study lends good support for the importance of conducting future research which investigates the motivation to seek reassurance in an experimental design.

## Connecting Narrative

A subtle theme that connects all my research projects is *support*. For my SIP the focus was on evaluating suicide risk training for GPs so that they were equipped to *support* patients presenting with risk. For my critical review of the literature the focus was on bereavement *support* options for caregivers. For my main research project the focus was on excessive reassurance seeking which could be described as a form of *support* people give to help people suffering from OCD and depression. Furthermore, the overall aim of all this research is to help *support* clinicians to increase their understanding around these topics areas. This narrative will outline my experience of conducting my main research project, critical review of the literature, service improvement project and case studies.

### Service Improvement Project

The idea for my Service Improvement Project (SIP) came from my first placement in a primary care mental health service for adults. The service worked closely with General Practitioners (GPs) and staff members frequently liaised with them about risk issues in relation to any of their patients. For this reason, I was interested in finding out about the GPs knowledge of risk management. My placement supervisor, Dr Rosa Hoshi, recommended that I spoke to Hannah Foster (high intensity mental health practitioner) about this as she had contact with GP surgeries on a regular basis. From meeting with Hannah I discovered that the primary care service provided suicide risk training for GPs. My placement supervisor and I discussed this further in supervision and she felt that there was an opportunity to evaluate the suicide risk training that was being offered.

Once the project had been developed and the proposal was passed I had to contact Avon and Wiltshire Partnership Research and Development (AWP R&D) department to inform them of the project. They confirmed that the research constituted as a service evaluation project. I then applied for ethical approval from the University of Bath Psychology Research Ethics Committee and this was reviewed and confirmed.

### *Recruitment*

The biggest challenge of this project was recruiting GPs to take part in the research. I had spoken to some colleagues in the team who recommended that I spoke to the practice manager about the research so that they could inform GPs of the research at the practice

meetings. I asked if I could attend these meetings but they were booked up months in advance of when I wanted to attend and the practice managers did not think that this would be the best way to approach it. Instead they recommended that they spoke to the GPs about taking part in the study on my behalf and said they would contact me with the GPs response. Therefore it was vital that I pitched the research well to the practice managers as this was likely to positively impact on how the research was then presented to GPs. It quickly being apparent that the practice managers were extremely busy and unlikely to get back to me. In order manage this I created a database for recording the details of all the practice managers I had spoken to, the outcome of the conversation and an appropriate date for follow up. Ultimately, I spent the summer months of year one calling GP practices for up to 8 hours a day. The database helped to ensure that all GP practices were contacted.

### *Learning*

I presented my findings from this project to the whole team. A member from public health also attended the presentation as she wanted to feedback the findings to the suicide prevention strategy team. It was helpful to present the report back to the team as it allowed me to practice delivering service feedback in a clear, concise and sensitive manner. The results were well received and I received positive feedback from the presentation. I am also hoping to use the findings from this research to inform the delivery of some training to GPs on my final placement.

I really valued having the opportunity to complete a service focused piece of research as this is something that I would like to continue to complete as part of any future Clinical Psychologist post. I was interested to learn that despite the growing awareness and concern around suicide, there is lack of service provision around ensuring that GPs receive high quality training. The research project highlighted a role for Clinical Psychologists to get involved in sharing this knowledge and either consulting on way to improve GP training and or by directly helping to train GPs around risk management. This is a piece of research that I would be interested in developing further in the future.

### **Critical review of the literature**

This project was focused on caregiver bereavement support provided by hospices. The idea was suggested by one of my second year placement supervisors, Dr Anna Lagerdahl, who I worked with in a hospice. Anna had been to a conference where the authors of the Dual



Process Model of Bereavement (Stroebe and Schut) had spoken about the need for someone to conduct a literature review in this area. I was familiar with the bereavement literature as this was something that I had studied as an undergraduate so it sounded like it would be an interesting project. Unfortunately due to staff changes my internal supervisor for the project changed four times so for a long time I was unable to get any momentum around starting the project. This was one of the most stressful parts of completing the project as I was trying to initiate a project which I had no previous experience in completing. However, this encouraged me to branch out to different resources, such as my peers, for support. Consequently when I met with my final supervisor at the start of third year, I was more confident about what I wanted to do and she was supportive of my idea and helped to move the project forward.

### *Learning*

I had never completed a critical review of the literature before so everything from a search string to measures of methodological quality was new to me. The development of my knowledge around this project was support by my academic supervisor, my external supervisor, my peers and wider reading. I believe this is a valuable skill to have and something that will help me in any future research as it is a reliable way of reviewing the literature.

The hardest part of this project was writing up the discussion section. However, when I met with my external supervisor, Dr Anna Lagerdahl, she asked me to summarise the main points I had taken away from reviewing the literature. As I spoke she wrote down the ideas and these were then used as headings to structure my discussion. This meeting highlighted the importance of stepping back from the literature to think about what I wanted to portray to anyone reading my work. This is a good tip that I will continue to use and share with others in the future with any write up.

### **Main research project**

My main research project investigated excessive reassurance seeking in people with OCD and depression. This project involved recruiting patients in the NHS and therefore I was required to seek approval from IRAS. I completed the IRAS application and requested a proportionate review. This was rejected so I arranged a telephone call for a full Research Ethics Committee (REC) meeting. This went surprisingly well as the panels main concerns

were around some of the wording on my participant information sheet and how I would manage any risk issues. My supervisor for this project was Paul Salkovskis and we had already gone through the risk protocol so we were clear about how this would be managed and they were happy with our response. I then had to seek AWP R&D approval and this was approved almost straight away.

### *Recruitment*

I recruited people with depression and OCD. I had contacted primary care mental health services, secondary care mental health services and OCD-UK. Twitter was also used to help market the research. In addition to these services I also used 'everyone included' to help with recruitment. This is an AWP run service that helps to recruit by conducting an initial search of potential participants, based on the research screening criteria. Once potential participants have been identified they are sent a letter asking if they would like to take part in research. If they want to take part they can get in touch and ask for their number to be passed on to the researcher. I had a lot of responses from people who had signed up to 'everyone included'. However, a large number of these people could not take part as they did not meet the inclusion criteria for the research. This was a massive shame as there were lots of people who were eager to take part in research. It also became apparent that after 'everyone included' had agreed to help with my recruitment, they started to charge a fee to anyone else who wanted to access the service so it was lucky that I applied early enough.

One of the most difficult things to manage when speaking to people on the telephone was risk of harm to self. I had one person who disclosed something that put her at risk of harm which meant I had to break confidentiality and share this information. I felt better once this information was shared, but in the time it took to contact the relevant person, it was extremely anxiety provoking. My academic supervisor was supportive of how this situation was managed and his positive feedback helped reassure me that I was approaching risk management in the right way.

Overall, I had a great response from people who saw the research advertised with OCD-UK and some people contacted me from America and Australia to ask if they could take part in my research after seeing it advertised on the OCD-UK website. The majority of people taking part in my research was supportive of the work I was doing and this was

reflected by how many people asked for me to send them a summary of my results once the research was completed.

### *Learning*

From carrying out this piece of research I am now aware of how to design a research project and apply for research ethics and R&D. This has been an incredibly rich learning experience for me as I had little experience in conducting research before starting the course. I would now feel comfortable completing further research and supervising projects.

The biggest challenge was conducting the statistical analysis and interpreting the results. Whilst this was time consuming and required a lot of thought and consideration, it was a rewarding, once the results were written up.

### **Case studies**

From completing the case studies I have learned about the importance and usefulness of embedding research into clinical practice. The case studies I completed focused upon the CBT work I had done. I specifically chose to write up this work so I could test out the effectiveness of the interventions in line with the evidence base. My first placement was in an IAPT service so I quickly became familiar with collecting session by session outcome measures. In this setting, I felt as though some of the measures I had to collect were only for the service benefit and I was not surprised that some of the clients that I worked with would question the benefits that this would have for them. By second year I had become more skilled at intertwining the importance of data collection for service monitoring with clinical benefits for the client. I was therefore using questionnaires to help inform the therapeutic intervention, to monitor change and to discuss any barriers to symptom improvement.

Three of my case studies were single case experimental designs. I enjoyed writing these up as they provided me with a space to fully explore the literature relating to the case I was working with. They also encouraged me investigate with the client how things were before therapy begun so that I could gauge how their baseline scores related to what they were thinking, feeling and doing. Furthermore, it was helpful to use the outcome measures more interactively in therapy as I was crosschecking any increase or decrease in scores with the intervention that had been done to see if this matched with what the client reported was

helping. Unfortunately due to the short time spent on placement I was never able to complete a follow-up measure as I always worked with the client until the final week of placement. This was a shame as it would have been interesting to have measured how the clients had done once therapy had stopped. This is something that I could bear in mind for any future cases that I write up or supervise.

### *Learning*

Overall all my case studies supported the evidence base around the effectiveness of providing CBT for the treatment of anxiety and mood related mental health illnesses. The case studies were based on people who had support from either their family or friends. This may be a key factor that helped contribute to an improvement in their symptoms and overall functioning. I am now a strong advocate of using evidence based practice to inform any therapeutic work and value the added contribution that outcome measures can offer in terms of understanding the client's experiences and symptoms. In the future I would like to help incorporate the practice of evidence based working and use of outcome measures into my teams working culture.

### **Summary**

The research I have completed has either focused on evaluating, understanding or improving the support that either family, friends or professionals give to people. The key learning point that I will take away from this experience is that family, friends and professionals can help change outcomes and people can get better when they have the right support from others. For those clients who do not have support from family and friends, I see it as my role to notice, reach out and help.

At times it was challenging to manage the competing demands that three separate research projects pose. However, I have really enjoyed learning about different types of research and I have completed three really interesting research projects. Whilst the course provided some teaching around the research topics, my main sources of learning came from my supervisors, peers and wider reading.

All my research projects have been developed with the support and encouragement from my academic and external supervisors who have helped me to complete the projects to the highest standard. I have developed an array of research skills which I will utilize in any

future clinical or research work. Whilst I would like to pursue a career as a clinician once I graduate, I hope to continue to be involved in research in one way or another. I have a particular interest in service design and delivery so completing service improvement projects might be one way of ensuring that I am using research to inform any future work that I am involved in.

## **Appendix A – Bereavement Care Instructions for Authors**

- Most of our readers will have completed some form of counselling training and read a basic text on bereavement. Consequently, some understanding of the topic can be assumed, although we try to avoid the use of jargon in order to make the material accessible to readers from a variety of disciplines. Articles should be consistent with the aims and scope of the journal.
- Manuscripts are accepted in English. Any consistent spelling and punctuation styles may be used. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 40 words or more should be indented without quotation marks.
- A typical manuscript will not exceed 5000 words including tables, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- [Abstracts](#) of 150 words are required for all manuscripts submitted.
- Each manuscript should have 4 to 6 [keywords](#).
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance [here](#).
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-

authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

- Biographical notes on contributors are not required for this journal.
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
  - *For single agency grants:* "This work was supported by the [Funding Agency] under Grant [number xxxx]."
  - *For multiple agency grants:* "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."
- Authors must also incorporate a [Disclosure Statement](#) which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to [SI units](#). Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

## Figures

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).

- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.



## **Appendix B – *BMJ Quality & Safety* Instructions for Authors**

Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0).

### **Title and Abstract**

1. Title: Indicate that the manuscript concerns an initiative to improve healthcare (broadly defined to include the quality, safety, effectiveness, patient centeredness, timeliness, cost, efficiency, and equity of healthcare).

2. Abstract: a. Provide adequate information to aid in searching and indexing, b.

Summarize all key information from various sections of the text using the abstract format of the intended publication or a structured summary such as: background, local problem, methods, interventions, results, conclusions.

### **Introduction - Why did you start?**

3. Problem/Description: Nature and significance of the local problem.

4. Available knowledge: Summary of what is currently known about the problem, including relevant previous studies.

5. Rationale: Informal or formal frameworks, models, concepts, and/or theories used to explain the problem, any reasons or assumptions that were used to develop the intervention(s), and reasons why the intervention(s) was expected to work.

6. Specific aims: Purpose of the project and of this report.

### **Methods - What did you do?**

7. Context: Contextual elements considered important at the outset of introducing the intervention(s).

8. Intervention(s): a. Description of the intervention(s) in sufficient detail that others could reproduce it, b. Specifics of the team involved in the work

9. Study of the Intervention(s): a. Approach chosen for assessing the impact of the intervention(s), b. Approach used to establish whether the observed outcomes were due to the intervention(s).

10. Measures: a. Measures chosen for studying processes and outcomes of the intervention(s), including rationale for choosing them, their operational definitions, and their validity and reliability, b. Description of the approach to the ongoing assessment of contextual elements that contributed to the success, failure, efficiency, and cost, c.

Methods employed for assessing completeness and accuracy of data.

11. Analysis: a. Qualitative and quantitative methods used to draw inferences from the data, b. Methods for understanding variation within the data, including the effects of time as a variable.

12. Ethical Considerations: Ethical aspects of implementing and studying the intervention(s) and how they were addressed, including, but not limited to, formal ethics review and potential conflict(s) of interest.

### **Results - What did you find?**

13. Results: a. Initial steps of the intervention(s) and their evolution over time (e.g., time-line diagram, flow chart, or table), including modifications made to the intervention during the project, b. Details of the process measures and outcome, c. Contextual elements that interacted with the intervention(s), d. Observed associations between outcomes, interventions, and relevant contextual elements, e. Unintended consequences such as unexpected benefits, problems, failures, or costs associated with the intervention(s), f. Details about missing data.

### **Discussion - What does it mean?**

14. Summary a. Key findings, including relevance to the rationale and specific aims, b. Particular strengths of the project.

15. Interpretation: a. Nature of the association between the intervention(s) and the outcomes, b. Comparison of results with findings from other publications, c. Impact of the project on people and systems, d. Reasons for any differences between observed and anticipated outcomes, including the influence of context, e. Costs and strategic trade-offs, including opportunity costs.

16. Limitations: a. Limits to the generalizability of the work, b. Factors that might have limited internal validity such as confounding, bias, or imprecision in the design, methods, measurement, or analysis, c. Efforts made to minimize and adjust for limitations.

17. Conclusions: a. Usefulness of the work, b. Sustainability, c. Potential for spread to other contexts, d. Implications for practice and for further study in the field, e. Suggested next steps.

### **Other information**

18. Funding: Sources of funding that supported this work. Role, if any, of the funding organization in the design, implementation, interpretation and reporting.

## Appendix C – Suicide risk training questionnaire



### Evaluation of the risk training programme delivered by LIFT psychology

This evaluation will aim to discover the effectiveness of the suicide risk training programme provided by LIFT psychology and will assess the factors that facilitate and restrict whether GPs accept the suicide risk training.

1) Have you received the suicide risk training from LIFT psychology?

Yes – please proceed to question 8      No – please proceed to question 2

2) Have you been offered the suicide risk training but not taken up the offer?

Yes – please proceed to question 3      No – please proceed to question 4

3) What are your reasons for not doing the suicide risk training? (Please tick all that apply)

- ☐ A suitable date/time could not be agreed
- ☐ I don't have enough time to carry out the training
- ☐ I do not know what the training consists of
- ☐ I do not need the training as I know how to assess suicide risk
- ☐ The training is self-explanatory
- ☐ Other (please specify below)

.....  
.....

4) Have you had any other form of suicide risk training in the last 3 years?      Yes/No

5) If yes, what

training?.....

6) Is there any training regarding suicide risk that you think you would benefit from?

Please describe:

.....  
.....

.....  
.....  
7) Would you like to do the suicide risk training provided by LIFT?

Yes – **please fill in contact details overleaf** No – thank you completing the questionnaire

**Only continue if you HAVE done the risk training provided by LIFT psychology**

8) Why did you accept the suicide risk training? (please tick all that apply)

- ☐ To learn how to manage risk
  - ☐ The practice manager recommended it
  - ☐ Other (please specify below)
- .....  
.....

9) How useful did you find the suicide risk training? (1 = not very useful, 10 = extremely useful)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

10) Did the suicide risk training equip you with the knowledge to differentiate between low, medium and high risk?

Yes/No

11) Are you aware of the indicators of suicide risk?

Yes/No

12) How long was spent on training?

10-20mins    ☐    20-30mins    ☐    30-40mins    ☐    40mins + ☐

13) Was any aspect of the suicide risk training unclear?

Yes/No

If yes, please specify below:

.....  
.....  
.....

14) Was the suicide risk training targeted at an appropriate level?

Yes/No

If no, how could the suicide risk training be improved?

.....  
.....  
.....  
.....

15) Has the suicide risk training equipped you with the skills necessary to carry out suicide risk assessments confidently?

Yes/ No

If no, how could the suicide risk training be improved?

.....  
.....  
.....  
.....

16) Are there any aspects that you are unsure about in regards to suicide risk assessments?

Yes/ No

If yes, please specify

.....  
.....

17) Do you feel you need any additional training?

Yes/No

**(If yes, please fill out contact details overleaf)**

What aspect of the suicide risk training do you use in practice? (please tick all that apply)

- ☐ Risk assessment form
- ☐ Risk flow chart
- ☐ Keeping safe leaflet

**Yes I would like to do the risk training. Please contact me via the contact details below**

Name:

Number:

Email:

**Your information will be passed on to the Swindon LIFT psychology team so they can contact you about the suicide risk training.**

## **Appendix D – Service improvement project participant information sheet**



### **Participant information sheet**

You are being invited to participate in a service improvement project which is going to evaluate the suicide risk training programme provided by LIFT psychology to GPs. You have been invited to take part because you are a GP in Swindon who should have been offered the suicide risk training from LIFT psychology. Your experience of the training is of great importance to us, as is the advice and recommendations you can give.

Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. I would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

#### **Why the study is being done?**

This study is being carried out to evaluate the suicide risk training programme provided by LIFT psychology to GPs.

#### **What it will involve?**

The research will involve you completing a short 2 page questionnaire. You have the right to withdraw from the study at any point by contacting myself on the details below and providing your questionnaire number.

#### **What will be done with the questionnaires?**

The data from the questionnaire will be analysed and then used to write a report which will be presented to the team at LIFT psychology in Swindon. The report will form part of my research portfolio which will be presented to Bath University. You can request any of the materials produced from the study.

#### **Confidentiality**

All questionnaires will be numbered and you will be referred to via the numbering system to secure your anonymity. The data will be published anonymously and the questionnaires will be kept securely and, once analysed, destroyed.

If you have any questions or would like more information, please contact me on the details below. If you would like to talk to someone else then please contact James Gregory who is supervising the project and a member of the research team at Bath University: **J.D.Gregory@bath.ac.uk**. When contacting James please provide details of the name or description of the study, the researcher(s) involved, and the details of the complaint you wish to make.

This study has received ethical approval from Bath University. Thank you for taking your time to read this.

**If you have any further questions please contact:**

Emma Smith - Clinical Psychologist in training

Phone number: 0151 794 1410      Email: es600@bath.ac.uk

Address: Department of Psychology, Claverton Down, Bath, North East Somerset BA27AY

## Appendix E – Service improvement project consent form

Consent form		
<b>Title of Service Improvement Project:</b>	<b>An evaluation of the risk training programme provided by LIFT psychology to GPs.</b>	<b>Please tick box</b>
<b>Researcher:</b>	Emma Smith	

1. I confirm that I have read and have understood the information sheet dated 20.05.14 for the above project. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I agree to take part in the above study. ☐
5. I am willing for the data from my questionnaire to be used in presentations and publications by the Researcher on the understanding that all identifying features will be removed and I cannot be identified ☐

_____	_____	_____
Participant Name	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

_____	_____	_____
Researcher	Date	Signature

### The contact details of lead Researcher (Principal Investigator) are:

Emma Smith - Clinical Psychologist in training

Contact number: 0151 794 1410,

Contact email: es600@bath.ac.uk or e.smith24@nhs.net

Department of Psychology, Claverton Down, Bath, North East Somerset BA2 7AY



## **Appendix F – Behaviour Therapy and Experimental Psychiatry Instructions for Authors**

### **NEW SUBMISSIONS**

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.

As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay-out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

### ***References***

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

### ***Formatting requirements***

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.  
Divide the article into clearly defined sections.

### ***Figures and tables embedded in text***

Please ensure the figures and the tables included in the single file are placed next to the relevant text in the manuscript, rather than at the bottom or the top of the file.

### **Article structure**

#### ***Subdivision - numbered sections***

Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

#### ***Introduction***

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

### ***Material and methods***

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

### ***Results***

Results should be clear and concise.

### ***Discussion***

This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

### ***Conclusions***

The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

### ***Appendices***

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

## **Essential title page information**

- ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
- ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
- ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

## **Abstract**

A concise and factual abstract is required. The abstract should be structured, using the following headings: *Background and Objectives; Methods; Results; Limitations; Conclusions.* Maximum length is 250 words, including headings. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should be avoided, but if essential they must be defined at their first mention in the abstract itself.

A Graphical abstract is optional and should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership online. Authors must provide images that clearly represent the work described in the article. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of  $531 \times 1328$  pixels (h  $\times$  w) or proportionally more. The image should be readable at a size of  $5 \times 13$  cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files.

### **Keywords**

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

### ***Abbreviations***

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

**Appendix G – Reassurance seeking questionnaire (the questions that have been added are underlined and bold)**

**DEMOGRAPHIC INFORMATION**

Please answer the following questions:

Your name: \_\_\_\_\_

1. Gender: ☐ female ☐ male (please tick one)

2. Age: \_\_\_\_ years (please fill in)

3. What is your ethnic group?

- ☐ Asian
- ☐ Black (Caribbean, African, Others)
- ☐ Caucasian
- ☐ Mixed Background
- ☐ Others: \_\_\_\_\_

4. What is your relationship status?

- ☐ Single
- ☐ Dating
- ☐ Cohabiting
- ☐ Married
- ☐ Separating
- ☐ Divorced
- ☐ Widowed
- ☐ Other: \_\_\_\_\_

5. What is your highest educational qualification

- ☐ Secondary (e.g. GCSE, O-Levels, GNVQ)
- ☐ Degree
- ☐ Postgraduate

6. Would you like to receive a summary\* of the study results sent to you?

☐ Yes ☐ No

If yes, please provide your email or postal address:

\_\_\_\_\_

\*This summary excludes any identifiable characteristics and will be focused on providing a general overview of the key findings

## The Reassurance Seeking Questionnaire

Often when people feel anxious or distressed they seek reassurance. The questions below are about ways in which you might try to get reassurance, the effects of seeking reassurance on your feelings or mood, and what impact reassurance seeking has on you and on other people.

Please rate each item of the questionnaire using the following scale and circle around the number you find most fitting.

Never (0)   Rarely (1)   Sometimes (2)   Often (3)   Very often (4)   Always (5)

- |   |             |
|---|-------------|
| (1) I ask for reassurance from my family  | 0 1 2 3 4 5 |
| (2) I believe that my anxiety will not go down until I get reassurance  | 0 1 2 3 4 5 |
| (3) I ask others to do things as a way of reassuring me   | 0 1 2 3 4 5 |
| (4) When I seek reassurance I try not to ask too many times so I don't upset or annoy the person  | 0 1 2 3 4 5 |
| (5) <b><u>If I notice the person getting irritated when I am seeking reassurance I seek it more</u></b>                                 | 0 1 2 3 4 5 |
| (6) I ask for reassurance from people I know  | 0 1 2 3 4 5 |
| (7) When I seek reassurance I repeat what the person says so that they can confirm it   | 0 1 2 3 4 5 |
| (8) When someone is giving me reassurance I look carefully at the person to see if they are confident about what they say to me         | 0 1 2 3 4 5 |
| (9) When I seek reassurance I ask the person to repeat what they said to me   | 0 1 2 3 4 5 |
| (10) <b><u>If people do not give me reassurance it is because they do not care enough about me</u></b>                                  | 0 1 2 3 4 5 |
| (11) AFTER I have sought reassurance I feel guilty  | 0 1 2 3 4 5 |
| (12) I use phrases (e.g., Is this all right?) so that the person won't know that I am seeking reassurance                               | 0 1 2 3 4 5 |
| (13) I ask for reassurance from people close to me  | 0 1 2 3 4 5 |
| (14) I show my appreciation (e.g., say 'thank you') to make the person comfortable with giving reassurance                              | 0 1 2 3 4 5 |
| (15) <b><u>I seek reassurance to try and stop people rejecting me</u></b>   | 0 1 2 3 4 5 |
| (16) I find it hard to resist seeking reassurance   | 0 1 2 3 4 5 |
| (17) <b><u>I seek reassurance a lot from people close to me because I do not believe my relationship (with them) is very secure</u></b> | 0 1 2 3 4 5 |
| (18) AFTER I have sought reassurance I feel frustrated  | 0 1 2 3 4 5 |
| (19) When I seek reassurance it brings me closer to the other person  | 0 1 2 3 4 5 |

(20) I seek reassurance from other people even when I can see that it frustrates them	0 1 2 3 4 5
(21) If possible, I will continue to seek reassurance until I feel certain	0 1 2 3 4 5
(22) When I seek reassurance I become annoyed if the person answers in an inconsistent manner	0 1 2 3 4 5
(23) When I seek reassurance I feel it reduces the burden of responsibility	0 1 2 3 4 5
(24) If I do not get reassurance in the 'right way' I seek it until I get it	0 1 2 3 4 5
(25) I feel that seeking reassurance can make my problems worse	0 1 2 3 4 5
(26) AT THE TIME I seek reassurance it makes me feel frustrated	0 1 2 3 4 5
(27) I ask for reassurance from my partner	0 1 2 3 4 5
<b>(28) <u>I seek reassurance to prevent myself feeling unloved</u></b>	0 1 2 3 4 5
(29) When I seek reassurance I look for mistakes and contradictions in how people answer my questions	0 1 2 3 4 5
(30) If possible, I will continue to seek reassurance until I feel 'just right'	0 1 2 3 4 5
(31) I avoid asking for reassurance because I know it frustrates other people	0 1 2 3 4 5
<b>(32) <u>I seek reassurance mainly because I hope that I can discover whether people important to me truly care about me</u></b>	0 1 2 3 4 5
(33) I seek reassurance more often than necessary	0 1 2 3 4 5
(34) I feel that nothing can substitute for reassurance	0 1 2 3 4 5
(35) Seeking reassurance is counter-productive for me	0 1 2 3 4 5
<b>(36) <u>I seek reassurance to try to improve how secure my relationship is</u></b>	0 1 2 3 4 5
(37) People feel frustrated when I seek reassurance from them	0 1 2 3 4 5
<b>(38) <u>I seek reassurance even though doing this might damage how much they care about me</u></b>	0 1 2 3 4 5
(39) I disagree with people who say that reassurance seeking is unhelpful for me	0 1 2 3 4 5
(40) When I seek reassurance I try to analyze whether the person fully understands my worry	0 1 2 3 4 5
<b>(41) <u>I seek reassurance as a way of increasing how secure my relationship is</u></b>	0 1 2 3 4 5
(42) My reassurance seeking puts strain on other people	0 1 2 3 4 5
(43) I seek reassurance to make sure there is nothing wrong with my health	0 1 2 3 4 5
<b>(44) <u>I seek reassurance about whether those I care for value me in the way I want them to</u></b>	0 1 2 3 4 5
(45) I repeatedly ask others for reassurance until I am sure they understand what I am worried about	0 1 2 3 4 5

## Appendix H – IRAS ethical approval letter



# Health Research Authority

## National Research Ethics Service

### NRES Committee North West - Lancaster

Barlow House  
3rd Floor  
4 Minshull Street  
Manchester  
M1 3DZ

Telephone: 0161 625 7818

Fax: 0161 625 7299 28 May 2015

Miss Emma Smith  
Trainee Clinical Psychologist  
Taunton & Somerset Foundation Trust  
Department of Psychology, University of Bath  
Claverton Down  
Bath  
BA2 7AY

Dear Miss Smith

<b>Study title:</b>	<b>Identifying different styles and effects of reassurance seeking</b>
<b>REC reference:</b>	<b>15/NW/0388</b>
<b>IRAS project ID:</b>	<b>170745</b>

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Mrs Carol Ebenezer, [nrescommittee.northwest-lancaster@nhs.net](mailto:nrescommittee.northwest-lancaster@nhs.net). Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

## Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

## Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is



that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

## Ethical review of research sites

### NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Online charity invitation to take part in research]	1	17 March 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UMAL Professional indemnity insurance]	1	01 August 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University Indemnity Insurance]		01 August 2015
Letter from sponsor [University of Bath]	1	08 April 2015
Letter from statistician [Academic approval]		20 March 2015
Non-validated questionnaire [Demographic & RSQ]		
Other [Research Opportunity letter]	1	07 February 2015
Other [No Opinion Letter from Liverpool Central PRSC]		30 April 2015
Other [Flyer for healthy volunteers]	1	21 May 2015
Participant consent form [Consent form]	1	15 April 2015
Participant information sheet (PIS) [Participant information sheet for clinical sample]	2	21 May 2015
Participant information sheet (PIS) [PIS for healthy volunteers]	1	21 May 2015
REC Application Form [REC_Form_23042015]	4.0.0	16 April 2015
Research protocol or project proposal [Research protocol]	1	18 March 2015
Summary CV for Chief Investigator (CI) [Emma Smith]		
Summary CV for student [Emma Smith]		
Summary CV for supervisor (student research) [Paul Salkovskis]		
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Summary of research]	1	11 March 2015
Validated questionnaire [Obsessive compulsive inventory]		

Validated questionnaire [GAD7]		
Validated questionnaire [PHQ9]		
Validated questionnaire [MINI]	6.0.0	10 October 2010

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

### Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

## User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/>

## HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L Booth', with a small 'pp.' written below it.

**Dr Lisa Booth Chair**

Email: [nrescommittee.northwest-lancaster@nhs.net](mailto:nrescommittee.northwest-lancaster@nhs.net)

*Enclosures:* "After ethical review – guidance for researchers"

*Copy to:* Jane Millar, University of Bath  
Ms Hannah Antoniadou, Avon and Wiltshire Mental Health Partnership NHS trust

## Appendix I – Everyone Included letter



Everyone Included  
AWP Research and Development  
Blackberry Centre  
Blackberry Hill Hospital  
Bristol, BS16 2EW  
**Tel:** 0117 378 4535  
**Email:** [awp.researchforall@nhs.net](mailto:awp.researchforall@nhs.net)

Hello!

The Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is your local mental health NHS Trust. We are an Everyone Included trust which means we aim to let people know about research opportunities in which they may be interested, unless they tell us otherwise. This gives everyone the chance to choose for themselves if they would like to take part in research.

### **The following information is about a research study you might be interested in.**

This study is looking at different ways people approach and react to reassurance seeking. This study aims to increase understanding of how people seek reassurance and how people who have problems with this might be helped in the future.

If you are interested in this study, a researcher will call you and carry out a brief telephone interview to make sure you can take part; this will take about 15 minutes. If you are suitable for the study and would like to take part, you would be asked to complete some questionnaires. These will be posted out to you and will take approximately 30 minutes to complete. A freepost envelope will be included for you to send the questionnaires back once completed. Your answers will be strictly anonymous and confidential. No-one looking at the study findings will be able to identify you in any way. If you decide to take part, you will be posted a £5 voucher as thank you for your time once the study team has received the completed questionnaires back.

If you think you would like to be involved and would like to find out more, please contact the Everyone Included team at AWP by phone, email or post.

**Phone:** 0117 378 4533, **Email:** [awp.researchforall@nhs.net](mailto:awp.researchforall@nhs.net) **Post** (see next page for postal reply slip).

If you choose to get in touch with us, this does not commit you to taking part. We are here to answer any questions you might have. Whether or not you choose to take part in the research will not affect your care in any way.

We look forward to hearing from you soon.

Signed Julian Walker (R&D Director) & (Study PI)

*If you would like to stop receiving information about research, please see the leaflet enclosed.*

**If you would like to let us know by post that you are interested, please complete this slip and use the freepost envelope included with this letter.**

I, the person named, below **would like** to get more information about the research study (RDEI\*\*\*)

Please contact me by (please tick and complete):

☐ Phone: \_\_\_\_\_

☐ Email: \_\_\_\_\_

☐ Post (fill in address): \_\_\_\_\_

\_\_\_\_\_

Print name \_\_\_\_\_

Signature \_\_\_\_\_

**Please place this slip in the freepost envelope provided or post to:**

Everyone Included  
AWP Research & Development  
Blackberry Centre  
Blackberry Hill Hospital  
Bristol  
BS16 2EW



## **Appendix J – Main research project Participant information sheet**



### **Participant Information Sheet**

*We would like you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.*

#### **Title of Project**

Identifying different styles and effects of reassurance seeking in general and in psychological problems such as OCD and Depression.

#### **Why is this study being done?**

We seek reassurance to reduce our fears and remove doubt. We are interested in looking at different ways people seek reassurance and its effects in general and in psychological problems such as OCD and Depression. It is expected that differences would have implications for the way service users and clinicians try to deal with reassurance seeking.

#### **Do I have to take part?**

No. You do not have to take part in the study. If you decide to take part and then later change your mind, you can withdraw without giving your reasons, and, if you wish, your data will be destroyed. However any data already anonymised will be retained. Taking part, or otherwise, in the study will in not affect the treatment that you are currently receiving or likely to receive in the future.

#### **What will I be asked to do if I take part?**

1. The main researcher, Emma Smith, will need to speak to you on the phone to complete a telephone interview to see if taking part in the study is appropriate.
2. If it is and you would like to take part we will then post a questionnaire pack to you and ask you to fill in 4 questionnaires about reassurance seeking, anxiety, depression and OCD. This will take approximately 30 minutes to fill in.
3. Once completed, you would need to post them back to us using a 'freepost' envelope.

#### **Where will the study take place?**

The screening interview will be done over the phone and the questionnaires will be sent to the address you provide us with.

#### **Will my experiences and reports be kept confidential?**

Yes. All information which is collected about you during the course of the research will be kept confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. This means that all paper-based and electronic information will be locked and password protected with access restricted to study personnel and any information about you will have your name and address removed so that you cannot be identified from it. The Research Governance Sponsor of this study, The University of Bath may monitor or audit this study to ensure that it is being conducted appropriately but your identity will not be revealed.

We hope to report our findings in academic/health related journals and present them to relevant health professionals at meetings and conferences. The findings will also contribute to Emma Smith's Doctorate in Clinical Psychology. You will not be identified in any reports or publications arising from the study.

#### **Are there any advantages/benefits from taking part?**

We cannot promise the study will help you directly but the information collected from you and other participants may help to improve our understanding of reassurance seeking. A further benefit of this type of research will be to inform the way service users and clinicians try to deal with reassurance seeking. You will also receive a £5 'love to shop' voucher once we have received your completed questionnaires.

#### **Are there any disadvantages/risks from taking part?**

We consider there to be minimal disadvantages e.g. the inconvenience of a telephone call and completing the questionnaires. However, the telephone call will be arranged at a time that is suitable for you and you can complete the questionnaires in your own time.

If you become upset during the telephone call, please raise it with the interviewer. It is possible that some people might find completing the questionnaires upsetting. If this happens please stop completing the questionnaires and contact the main researcher, Emma Smith, using the details below. It is important for you to understand that you are not required to discuss anything that you do not want to and you should discuss only the things which you feel are relevant. If you disclose risk of harming yourself or others confidentiality will have to be broken and the relevant authority will be informed.

#### **What if there is a problem?**

If you have any concerns or wish to complain about any aspect of the way you have been approached or treated as part of this study, you should initially contact the researchers, Emma Smith, Paul Salkovskis or Neil Carrigan who will do their best to answer your questions. Their contact details are provided at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure on 01249 468266 or you can contact the Research Governance Sponsor of this study, University of Bath. Please write to Jane Millar, Pro-Vice-Chancellor (Research), University of Bath, 4 West 3.22, BA2 7AY.

Every care will be taken to ensure your safety during the course of the study. The University of Bath, the Research Governance Sponsor of the study, has indemnity (insurance) arrangements in place for non-negligent harm, in the event that something does go wrong and you are harmed as a result of taking part in the research study. If you are harmed due to someone's negligence, then you may have grounds for legal action but you may have to pay for it.

#### **What to do next if I'm interested?**

If you would like to participate or wish to discuss the study further you can contact: Emma Smith, Trainee Clinical Psychologist, Professor Paul Salkovskis, Clinical Psychologist, or Neil Carrigan, Clinical Psychologist, using the details provided below:

<b>Emma Smith</b>	<b>Professor Paul Salkovskis</b>	<b>Neil Carrigan, PTS</b>
<b>Department of Psychology,</b>	<b>Department of Psychology,</b>	<b>Chatsworth House,</b>
<b>6 West, University of Bath,</b>	<b>6 West, University of Bath,</b>	<b>Bath road,</b>
<b>Bath, BA2 7AY</b>	<b>Bath, BA2 7AY</b>	<b>Swindon, SN1 4BP</b>
<b>Telephone: 07984400964</b>	<b>Telephone: 01225 384350</b>	<b>Telephone: 01793 715000</b>
<b>Email: <a href="mailto:Es600@bath.ac.uk">Es600@bath.ac.uk</a></b>	<b>Email: <a href="mailto:pms33@bath.ac.uk">pms33@bath.ac.uk</a></b>	<b>Email: <a href="mailto:neil.carrigan@nhs.net">neil.carrigan@nhs.net</a></b>

## Appendix K – Main research project consent form

### Consent form

#### Title of Main

**Research Project:** Reassurance seeking in OCD and Depression.

**Researcher:** Emma Smith

**Please  
tick box**

6. I confirm that I have read and have understood the information sheet dated for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
7. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
8. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
9. I understand that data collected during the study may be looked at by individuals from The University of Bath, from regulatory authorities, or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
10. I agree to take part in the above study. ☐
11. I am willing for the data from my questionnaire to be used in presentations and publications by the Researcher on the understanding that all identifying features will be removed and I cannot be identified ☐

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Participant Name

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Date

---

Signature

---

Researcher

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Date

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Signature

#### **The contact details of lead Researcher (Principal Investigator) are:**

Emma Smith, Clinical Psychologist in training

Contact email: es600@bath.ac.uk or e.smith24@nhs.net

Department of Psychology, Claverton Down, Bath, North East Somerset BA2 7AY